Supreme Court, U.S.
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No. 04-

IN THE

Supreme Court of the United States

LINDA ELLIS,

Petitioner,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Despite significant and virtually unrebutted medical evidence of disability that justified the payment of long-term disability benefits for an eight month period, Liberty Life Assurance of Boston (hereinafter "Liberty Life") reversed course and abruptly terminated the disability benefits Linda Ellis (hereinafter "Ellis") was receiving under an ERISA long-term disability insurance policy. After the District Court determined Ellis was entitled to those disability benefits, the Fifth Circuit reversed the District Court in a decision that seriously conflicts with the decisions of ten other Circuits and ignores the plain language of the policy. The dissent found that there was no basis to reverse the ERISA abuse of discretion finding by the District Court. Because the Fifth Circuit's majority opinion conflicts with other Circuits on issues that are important to ERISA jurisprudence, this Court should review the following questions:

1. Whether the Fifth Circuit's Overly Restrictive "Each and Every" Construction of "Disability" that Directly Conflicts with Decisions of the Second, Ninth and Tenth Circuits is Contrary to the Uniform Construction of Disability Insurance Policies Expected under ERISA?

2. Whether the Fifth Circuit's Rendition of Judgment in Favor of Liberty Life that Conflicts with the Decisions of the Vast Majority of Other Circuits is Contrary to the Substantial Evidence Requirement of the ERISA Abuse of Discretion Standard of Review?

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Linda Ellis respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

OPINIONS BELOW

The decision of the Court of Appeals is reported, as revised on January 13, 2005, at 394 F.3d 262 (5th Cir. 2005). The petition for rehearing and petition for rehearing en banc were denied on January 14, 2005. The Memorandum Opinion and Order, and Supplement to Memorandum and Order of the District Court are not reported. *See* Appendices A-D.

STATEMENT OF JURISDICTION

The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254 (1). The judgment of the Court of Appeals was entered on November 19, 2004. A petition for rehearing and a petition for rehearing en banc were timely filed on December 3, 2004. The petition for rehearing and petition for rehearing en banc were denied on January 14, 2005.

STATUTES INVOLVED

The relevant provisions of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132 are as follows:

> § 1132. Civil enforcement
>
> (a) Persons empowered to bring a civil action
>
> A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 *of this title*;

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other appropriate equitable relief

(i) to redress such violations or

(ii) to enforce any provisions of this subchapter or the terms of the plan . . .

STATEMENT OF THE CASE

In November 1999, Ellis, a mortgage loan officer with Chase Manhattan Bank ("Chase"), was no longer able to perform her duties as a mortgage loan officer due to a number of conditions, including fibromyalgia. In May 2000, after receiving short-term disability (STD) benefits for six months, Ellis began receiving benefits for long-term disability (LTD) from Liberty Life based on medical records and information it had received from her physicians demonstrating her inability to perform the material duties of her occupation. On December 22, 2000, after it had paid Ellis LTD benefits for eight months, Liberty Life abruptly terminated her LTD benefits effective December 31, 2000, noting that:

> . . . it is apparent you were ill and met the criteria for your policy's definition of disability initially based on the medical information received, you no longer meet your Long Term Disability Policy's definition of disability.

The material duties of Ellis' occupation at Chase included: performing at a rapid pace 100% of the time, meeting deadlines set by others 90% of the time, significant emotional distress, persisting in the face of obstacles, producing results that consistently meet or exceed expectations, funding a minimum of $500,000 each month, maintaining a branch customer satisfaction score of 85% good or better, driving for results, building constructive financial relationships, acquiring new opportunities, demonstrating technical/marketplace expertise, and managing the customer experience. Her job involved sitting 60% of the time, lifting 2% of the time, walking 10% of the time, standing 3% of the time, reaching 5% of the time, and driving 20% of the time.

The evidence in the administrative record demonstrated that Ellis had a Class 4 Physical Impairment and a Class 4 Mental Impairment attributable to the persistent pain she was suffering; she could not work an eight hour day; she could not perform on the job driving; she could not travel in a vehicle more than thirty minutes without pain medication; she was unable to walk or stand for any significant length of time; she could not lift, push, pull, climb stairs, or make fine movements with her hands; she had memory and cognitive problems attributable to her pain; she had difficulty sleeping and grooming herself; and she could not manage financial matters. Her physicians' records revealed she suffered multiple areas of pain on palpation; she suffered significant fatigue; she met the recognized diagnostic criteria for fibromyalgia; the results of her EMGs were suggestive of a myopathic process; and the results of a muscle biopsy were also suggestive of an inflammatory myopathy.

Even Liberty Life's selected expert, Dr. Croft, could not assess her limitations; he did not identify a single duty of her occupation as a mortgage loan officer that she could perform other than sitting; he also found she was tearful when he palpated her muscles; and he found that she walked with an antalgic gait.

In April 2001, the Social Security Administration (SSA) determined Ellis had been disabled since October 29, 1999; she suffered from inflammatory myopathy, diabetes and degenerative joint disease; her testimony concerning her inability to work and her severe pain complaints was credible evidence of her impairment; she could not perform her occupation as a mortgage loan officer; and she did not have any residual functional capacity to perform sedentary work on a sustained basis.

After Liberty Life "affirmed" its termination decision in an administrative appeal in March 2001, Ellis was forced to file suit. On June 3, 2003, the District Court determined that Liberty Life had abused its discretion when it terminated Ellis' LTD benefits in December 2000. In its Memorandum Opinion and Order, the District Court determined that Ellis qualified for LTD benefits, if she was unable to perform one or more of the material duties of her job. The District Court also found "no credible, substantial or positive evidence" that demonstrated Ellis, "once eligible, became ineligible for disability benefits". In its Supplement to Memorandum Opinion and Order, the District Court also found that Liberty Life's conduct was a bad faith breach of the fiduciary duties it owed to Ellis. The District Court entered a Judgment on August 3, 2003 awarding LTD benefits, attorneys fees and prejudgment interest to Ellis. This Judgment was modified by a subsequent Order entered by the District Court on October 20, 2003.

On appeal, the Fifth Circuit reversed the District Court and rendered judgment in favor of Liberty Life. In rendering its 2-1 opinion, the majority of the Fifth Circuit panel determined that the "only" construction of "Disability" required Ellis to prove she was unable to perform "each and every" material duty of her occupation to qualify for LTD benefits. Apparently, Ellis was not "disabled", because there was evidence she could sit. In reaching this conclusion, the panel majority ignored the plain language of the Liberty Life LTD policy and the recognized rules of construction for ERISA insurance policies. The majority also ignored prior applicable Fifth Circuit authority on this issue, and its decision directly conflicts with decisions of the Second, Ninth and Tenth Circuits construing similar "own occupation" disability provisions under ERISA. The decision was also

inconsistent with decisions of the Seventh, Tenth and Eleventh Circuits construing ERISA "any occupation" disability provisions.

The Fifth Circuit's panel majority also rendered judgment for Liberty Life, even though it identified no substantial evidence, medical or otherwise, in the administrative record that supported Liberty Life's termination of Ellis' LTD benefits. This holding is clearly contrary to the recognized abuse of discretion standard of review described by the vast majority of the other Circuits, and prior decisions of the Fifth Circuit. This holding is also contrary to this Court's opinion in *The Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003).

Judge Pickering filed a dissent. In his dissent, Judge Pickering noted that the construction of "disability" found by the District Court was a reasonable construction of the policy, and it should be enforced because it was consistent with the reasonable expectations of the insured, Ellis. Judge Pickering also found no concrete evidence in the administrative record that supported Liberty Life's decision to terminate Ellis' LTD benefits, no evidence that demonstrated Liberty Life's prior decision to pay LTD benefits to Ellis was incorrect, and no evidence that Ellis' medical condition had significantly changed. Under the ERISA abuse of discretion standard of review, Judge Pickering believed the Fifth Circuit was compelled to affirm the District Court's finding that Liberty Life abused its discretion.

Although the foregoing issues were raised in a petition for rehearing and a petition for rehearing en banc, the majority refused to correct its opinion and denied Ellis' petitions for rehearing on January 14, 2005.[1]

REASONS FOR GRANTING THE PETITION

1. The Fifth Circuit's Overly Restrictive Construction of "Disability" Conflicts with the Decisions of Other Circuits, and the Plain Language of the Chase LTD Policy.

As is well-recognized by the federal courts, the construction of an ERISA insurance policy begins with the provisions of the insurance policy. Liberty Life's LTD policy provides, in pertinent part, as follows:

> ***Section 2, Definitions***
>
> ***"Disability"*** or ***"Disabled"*** means during the Elimination Period and the next 24 months of Disability, the Covered Person is unable to perform all of the material and substantial duties of his occupation on an Active Employment basis because of an Injury or Sickness . . .

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[1] Judge Pickering's term expired in December 2004 and he did not participate in the consideration of the petitions for rehearing.

Section 4- Disability Income Benefits

Amount of Disability Monthly Benefit

To figure the amount of Monthly Benefit:

1. Multiply the Covered Person's Basic Monthly Earnings by the Benefit Percentage shown in the Schedule of Benefits.

Quick Recovery Program (Plus)

When proof is received that a Covered Person is Partially Disabled and has experienced a loss of earnings because of an Injury or Sickness, he may be eligible to receive a Loss of Earnings Monthly Benefit under Liberty's Quick Recovery Program (Plus).

To be eligible to receive such benefits, the Covered Person may be employed in his own occupation or another occupation and:

1. must satisfy the Elimination Period, and

2. must be earning 20% or more of his Pre-Disability Earnings.

If the Covered Person is earning less than 20% of his Pre-Disability Earnings, ***the Disability Benefit*** will be paid, and all other benefit provisions and terms applicable to ***Disability*** will apply as stated in this coverage.

For the purposes of this provision, the Covered Person may satisfy the Elimination Period if he is Disabled or Partially Disabled or a combination of Disabled or Partially Disabled during such time.

"***Partial Disability***" or "***Partially Disabled***" means as a result of the Injury or Sickness, the Covered Person is:

1. able to perform one or more, but not all, of the material and substantial duties of his own occupation or any other occupation on an Active Employment or a part-time basis, or

2. able to perform all of the material and substantial duties of his own or any other occupation on a part-time basis.

Amount of Loss of Earnings Monthly Benefit

To figure the amount of Monthly Benefit the formula (A divided by B) x C will be used:

A= The Covered Person's Pre-Disability Earnings minus the Covered Person's Basic Monthly Earnings received while he is Partially Disabled.

B= The Covered Person's Pre-Disability Earnings.

C= The Monthly Benefit as figured under the Disability provision of this coverage, (but not including adjustments under the Cost of Living Adjustment Benefit, if any).

(Emphasis added).

According to the majority opinion rendered by the Fifth Circuit, Ellis only qualifies for the "Disability Benefit" under the foregoing provisions, if she has a complete inability to perform "each and every" material and substantial duty of her occupation. If she can perform any single material duty of her occupation, she is not entitled to receive the "Disability Benefit". (App. A, *infra*, at pp. 12a, 16a-17a).

This construction of the foregoing provisions conflicts with decisions of the Second, Ninth and Tenth Circuits construing similar "own occupation" disability provisions in ERISA insurance policies; it conflicts with decisions of the Seventh, Tenth and Eleventh Circuits construing "any occupation" provisions in ERISA insurance policies; it ignores prior Fifth Circuit precedent that rejected such a construction; and it is contrary to the plain language of the foregoing provisions and the reasonable expectations of Liberty Life's insured, Ellis. Given the importance of uniformity in the construction of disability insurance policies under ERISA, these conflicts raise a substantial question of exceptional importance that justifies review by this Court.

A. The "Each and Every" Construction Adopted by the Fifth Circuit Conflicts with the Decisions of Other Circuits.

The Second, Ninth and Tenth Circuits have rejected, explicitly or implicitly, the "each and every" construction adopted by the majority of the Fifth Circuit panel in this case. These Courts of Appeals, utilizing the practical common sense approach recognized under ERISA, have each determined that the correct construction of "disability" allows an insured to recover total disability income benefits, if there is a task an insured cannot perform that is vital or essential to the insured's performance of her job. *Caldwell v. Life Insurance Company of North America*, 287 F.3d 1276, 1285-86 (10th Cir. 2002); *Kinstler v. First Reliance Standard Life Insurance Company*, 181 F.3d 243, 253 (2d Cir. 1999); *Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 458-59 (9th Cir. 1996); and *McClure v. Life Insurance Company of North America*, 84 F.3d 1129, 1133-34 (9th Cir. 1996).

A brief review of these Circuit Court cases further exemplifies the conflict this Court should resolve. In *McClure*, the Ninth Circuit construed a definition of "disability" that required the insured to prove "a complete inability ... to perform every duty of his occupation". 84 F.3d at 1133. The Ninth Circuit found the term "every" to be ambiguous, because it could mean "all" and it could mean "each". *McClure*, 84 F.3d at 1134. The *McClure* court construed the definition "in a practical sense" and found that "total disability exists if an employee is unable to perform one of the essential duties of his or her position". *Id.*

Saffle rejected "each and every" interpretations that either disqualify or qualify virtually every insured, as not wholly sensible or reasonable. 85 F.3d at 458-59. In *Saffle*, the Ninth Circuit found a reasonable interpretation of "Disability" to be one that required the insured to prove she was only unable to perform a substantial portion of her duties. 85 F.3d at 458.

The Second Circuit has determined that an inability to perform some, but not all, of the essential duties of an insured's job qualifies the insured for total disability. *Kinstler*, 181 F.3d at 253. In *Kinstler*, the insured was unable to perform the clinical duties of her job, such as providing direct patient care, and responding to medical crises; however, she could perform her sedentary administrative duties that comprised 60% of her job function. 181 F.3d at 247, 253. The Second Circuit determined the insured was entitled to LTD benefits, because she could not perform her clinical duties. *Kinstler*, 181 F.3d at 253.

In *Caldwell*, the insured was a customer service representative who had primarily sedentary duties, but who was also required to perform the heavy lifting duties of a rig hand as well. 287 F.3d at 1279-80. The definition of "disability" in the "own occupation" period was "unable to perform all the essential duties of his job". *Caldwell*, 287 F.3d at 1279. Although he admitted he could perform the sedentary duties of his job, the Tenth Circuit found that Caldwell could not perform all the essential duties of his job, because he could not perform the heavy lifting duties of a rig hand he was also required to perform. *Caldwell*, 287 F.3d at 1284-85. The Tenth Circuit agreed with a district court's determination that the insurer's denial of "own occupation" disability benefits to Caldwell was an abuse of discretion. *Caldwell*, 287 F.3d at 1285-86.

The Fifth Circuit's requirement that Ellis prove she is unable to perform "each and every" material and substantial duty of her occupation to recover "own occupation" disability benefits under ERISA cannot be squared with the practical, common sense approach of the Second, Ninth and Tenth Circuits. Instead, the Fifth Circuit has adopted a construction of "Disability" that these Circuits have recognized is not wholly sensible or reasonable. This Court should review this case to address this conflict.

The Seventh, Tenth and Eleventh Circuits have also determined that "any occupation" provisions in ERISA disability insurance policies should not be construed so literally that an insured must be utterly helpless to be considered disabled, because such an overly restrictive construction would render the plan totally meaningless and severely undermine the purposes of ERISA. *Hammond v. Fidelity and Guaranty Life Insurance Company*, 965 F.2d 428, 431 (7th Cir. 1992); *Torix v. Ball Corporation*, 862 F.2d 1428, 1430-31 (10th Cir. 1988); *Helms v. Monsanto Company, Inc.*, 728 F.2d 1416, 1420 (11th Cir. 1984). Yet, in this case the Fifth Circuit has adopted an overly restrictive construction of the Liberty Life LTD policy that severely undermines the purposes of ERISA and is inconsistent with these decisions of the Seventh, Tenth and Eleventh Circuits.

Under the Fifth Circuit majority's construction of "Disability", virtually every person who is conscious and able to perform any single material duty of their job, such as sitting or speaking, is disqualified from recovering disability benefits under Liberty Life's policy. This result conflicts directly with the opinion in *Torix*, where the Tenth Circuit found that such a policy was totally meaningless and its coverage was wholly illusory, because an insured

could only be paid benefits if she had "no conscious life". 862 F.2d 1430-31.

Adding to this confounding milieu, the Fourth and Sixth Circuits have acknowledged constructions of "disability" that are similar to the Fifth Circuit's "each and every" construction in the context of "elimination periods" under an ERISA disability insurance policy issued by Reliance Standard Life Insurance Company. *Carr v. Reliance Standard Life Insurance Company*, 363 F.3d 604, 606-07 (6th Cir. 2004); *Gallagher v. Reliance Standard Life Insurance Company*, 305 F.3d 264, 270 (4th Cir. 2002). However, it is also clear an insured under the Reliance Standard Life Insurance disability policy qualifies for total disability benefits after the elimination period, if the insured is only able to perform some of the material duties of his/her occupation. *Carr*, 363 F.3d at 606. Thus, these "each and every" constructions of the Fourth and Sixth Circuits only serve to further demonstrate the inconsistency between the Circuits on this important issue.

There is also a conflict within the Fifth Circuit on this issue that is a microcosm of the conflict among the various Circuits. The "each and every" construction adopted by the Fifth Circuit majority in this case was previously rejected by other panels of the Fifth Circuit and that construction is contrary to the "fair and reasonable" construction other panels of the Fifth Circuit had previously given to similar "disability" provisions. *Lain v. Unum Life Insurance Company of America*, 279 F.3d 337, 344-45 (5th Cir. 2002), and *Vercher v. Alexander & Alexander, Inc.*, 379 F.3d 222, 228-29 (5th Cir. 2004). Neither *Lain* nor *Vercher* were even mentioned in the Fifth Circuit panel's majority opinion in this case.

In *Lain*, Unum terminated the insured's total disability income benefits using an "each and every" construction similar to the one adopted by the panel in this case. The panel in *Lain* found Unum's construction was "contrary to the plain language of the policy", and the "fair and reasonable" construction of that language only required an insured to prove she was unable to perform a single material duty of her occupation to qualify for total disability income benefits. *Lain*, 279 F.3d at 344-45.

In *Vercher*, another panel of the Fifth Circuit rejected a similar "any and every" construction, because that interpretation went too far. 379 F.3d at 228-29. The disability provision at issue in *Vercher*, provided total disability income benefits if the insured was "completely unable to perform any and every duty of your regular occupation". 379 F.3d at 224. The *Vercher* panel determined that if the insured could prove she was "unable to perform something that was indispensable or essential to the proper performance of her regular occupation", she was entitled to total disability income benefits. 379 F.3d at 231.

Finally, as part of its analysis regarding the proper "construction" of "Disability", the majority of the panel criticized the District Court for relying on the following deposition testimony of Liberty Life's litigation manager, Paula McGee:

> Q. Under that definition, if Ms. Ellis could not perform one of the material duties of her occupation, she would be disabled?
>
> A. Yes.

(App. A, *infra*, at p. 13a). The majority of the panel noted that in a post-deposition Affidavit, McGee explained she was confused by this deposition question and provided testimony that contradicted her deposition answer. (*Id.*). Amazingly, the majority of the panel concluded that this affidavit testimony trumped the deposition testimony and tipped the scale in favor of Liberty Life on the cross-motions for summary judgment.

It is well-recognized that a litigant is bound by answers given during a deposition, despite a later contradicting affidavit, unless there is an explanation for the contradiction, and then the post-deposition affidavit only creates at most an issue of fact. *Cleveland v. Policy Management Systems Corporation*, 526 U.S. 795, 806-07 (1999) (citing authority from every Circuit). Of course, the Fifth Circuit majority's incredible conclusion turns this established rule of law completely on its head.

The construction of "disability" in ERISA insurance policies is an issue of vital importance to the millions of Americans who purchase disability insurance coverage through their employers. Uniformity is vital to the purpose of ERISA. Thus, this Court's review of this case is necessary to resolve the foregoing conflicts between the Circuits and promote the uniformity of construction of disability insurance policies that ERISA requires.

B. The Fifth Circuit's "Each and Every" Construction is Also Contrary to the Plain Language of the Liberty Life LTD Policy.

In its majority opinion, the Fifth Circuit panel rejected the construction of the terms "unable to perform all of the material and substantial duties of his occupation" adopted by the District Court on the basis of the panel's conclusion such a construction rendered the definition of "Partial Disability" under the Liberty Life policy meaningless. (App. A, *infra*, at pp. 14a-16a). In reaching this conclusion, the majority of the Fifth Circuit panel ignored or misconstrued significant provisions of the Liberty Life LTD policy pertaining to "Partial Disability". As a consequence, the majority's construction of the Liberty Life LTD policy is also contrary to the plain language of the insurance policy, contrary to well-recognized rules of construction for ERISA insurance policies, and contrary to the reasonable expectations of Liberty Life's insured, Ellis.

It is well-recognized an ERISA insurance policy must be construed in accordance with its plain language, as a whole, giving meaning to all its parts. *Lifson v. INA Life Insurance Company of New York*, 333 F.3d 349, 353 (2d Cir. 2003); *McOsker v. Paul Revere Life Insurance Company*, 279 F.3d 586, 588 (8th Cir. 2001). Accordingly, the Fifth Circuit was obligated to construe the definition of "Disability" in Section 2 of the Liberty Life LTD policy in conjunction with all of the provisions of Section 4, Disability Income Benefits, not just the definition of "Partial Disability" that is in Section 4.

Contrary to the implied assumption made by the Fifth Circuit's majority, there are not two mutually exclusive classes of benefits under Section 4 of the Liberty Life LTD

policy. All benefits payable to an insured under Section 4 are a function of the "Disability Benefit". The "Disability Benefit" is the insured's benefit percentage multiplied by her earnings. This "Disability Benefit" is paid to insureds who are "Disabled". This "Disability Benefit" is also paid to "Partially Disabled" insureds who are unable to earn at least 20% of their Pre-Disability Earnings.[2] A "Partially Disabled" insured who is earning 20% or more of her Pre-Disability Earnings is paid the Loss of Earnings Monthly Benefit that is a percentage of the "Disability Benefit". Thus, there is no way an insured could qualify for both "Disability" and "Partial Disability" benefits, as the Fifth Circuit's panel majority erroneously assumed to justify its "each and every" construction.

Rather, the plain language of the policy indicates that the "unable to perform all" provisions for "Disability" and the "able to perform one or more, but not all" provisions of the definition of "Partial Disability" are complementary, if not synonymous. As an example, if an insured cannot do her job and has no earnings, because she can only perform three out of seven of the material duties of her occupation; the insured is entitled to the "Disability Benefit" under Section 4. The only way this insured can receive the "Disability Benefit" promised by Section 4, is that the phrase "unable to perform all" includes "able to perform one or more, but not all".

Yet, under the panel majority's construction, this employee does not qualify for the "Disability Benefit", because she is "Partially Disabled". However, as a "Partially

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[2] The First Circuit has acknowledged this construction of the QRP provisions of the Liberty Life LTD policy. *Cook v. Liberty Life Assurance Company of Boston*, 320 F.3d 11, 22 (1st Cir. 2003).

Disabled" insured with no earnings, she is clearly entitled to the "Disability Benefit" under Section 4 of the policy. The panel majority's construction of "Disability" cannot be squared with the plain language of Section 4, but the District Court's construction of "Disability" is entirely consistent with it.

Even if it is assumed the "each and every" construction adopted by the Fifth Circuit's majority was a reasonable construction, it is obvious there are two reasonable constructions of these provisions, as Judge Pickering concluded in his dissenting opinion. (App. A, *infra*, at p. 30a). When the provisions of an ERISA insurance policy have two reasonable, but conflicting constructions, the language is ambiguous. In such circumstances, it is well-recognized that the ambiguity must be construed against the ERISA insurer, and in favor of the reasonable expectations of the ERISA insured. *Lifson*, 333 F.3d at 353; *Bynum v. Cigna Healthcare of North Carolina*, 287 F.3d 305, 313 (4th Cir. 2002); *Lain*, 278 F.3d at 345; *Perez v. Aetna Life Insurance Company*, 150 F.3d 550, 556-57 (6th Cir. 1998); *McClure*, 84 F.3d at 1133-34. Yet, the majority of the Fifth Circuit panel ignored these established rules of construction pertaining to ERISA insurance policies and adopted a construction that was clearly contrary to the interests of the ERISA insured, Ellis.

In fact, the Fifth Circuit majority's construction actually renders the coverage of the Liberty Life LTD policy illusory. Using the majority's construction of "Disability", many insureds, who expect they will receive disability benefits when they are unable to perform their occupation, will actually be denied those benefits; unless the insureds can satisfy the insurmountable burden of proving a complete

inability to perform each and every material duty of their occupation, including duties such as sitting.

Because the Fifth Circuit has ignored the plain language of the Liberty Life LTD policy and ignored the established rules of construction under ERISA, this Court must review this matter to ensure the uniform construction of insurance policies that ERISA requires.

2. The Fifth Circuit's Rendition in Favor of Liberty Life Conflicts with the Abuse of Discretion Requirements Recognized by the Vast Majority of the Circuits and Is Contrary to this Court's Opinion in *Nord.*

Under the ERISA abuse of discretion standard of review, the vast majority of the Circuits recognize that an insurer's decision to deny or terminate disability benefits is an abuse of discretion, if it is not supported by substantial evidence in the administrative record. *Stup v. Unum Life Insurance Company of America*, 390 F.3d 301, 307-08 (4th Cir. 2004); *Kosiba v. Merck & Company*, 384 F.3d 58, 69 (3rd Cir. 2004); *Fought v. Unum Life Insurance Company*, 379 F.3d 997, 1014-15 (10th Cir. 2004); *McDonald v. Western-Southern Life Insurance Company*, 347 F.3d 161 169-70 (6th Cir. 2003); *Hawkins v. First Union Corporation Long-Term Disability Plan*, 326 F.3d 914, 919 (7th Cir. 2003); *Cook v. Liberty Life Assurance Company of Boston*, 320 F.3d 11, 19, 23 (1st Cir. 2003); *Caldwell v. Life Insurance Company of North America*, 287 F.3d 1276, 1282-83 (10th Cir. 2002); *Lain v. Unum Life Insurance Company of America*, 279 F.3d 337, 342 (5th Cir. 2002); *Levinson v. Reliance Standard Life Insurance Company*, 245 F.3d 1321, 1325-27 (11th Cir. 2001); *House v. The Paul Revere Life Insurance Company*, 241 F.3d 1045, 1048 (8th Cir. 2001); *Pinto v. Reliance Standard Life*

Insurance Company, 214 F.3d 377, 392 (3rd Cir. 2000); *Zavora v. Paul Revere Life Insurance Company*, 145 F.3d 1118, 1122-23 (9th Cir. 1998); *Woo v. Deluxe Corporation*, 144 F.3d 1157, 1162 (8th Cir. 1998); *Donaho v. FMC Corporation*, 74 F.3d 894, 899-900 (8th Cir. 1996).

Substantial evidence is more than a mere scintilla, it is relevant evidence of a quality and quantity that a reasonable mind would accept as adequate to support a conclusion. *McDonald*, 347 F.3d at 171; *Caldwell*, 287 F.3d at 1282; *House*, 241 F.3d at 1048; *Woo*, 144 F.3d at 1162; *Donaho*, 74 F.3d at 900, n.10. Mere scraps of evidence that might or might not support a denial, skewed interpretations of medical records, selective recall of portions of medical records, demands for more tests, statements of possibilities by insurer-retained reviewing physicians, and conclusions of insurer-retained physicians who are not specialists qualified to address the insured's particular illness or condition are not sufficient, especially when there is substantial, if not overwhelming, evidence supporting disability in the administrative record. *Stup*, 390 F.3d at 309; *Kosiba*, 384 F.3d at 68-69; *McDonald*, 347 F.3d at 170-71; *Hawkins*, 326 F.3d at 918-19; *Cook*, 320 F.3d at 23; *Caldwell*, 287 F.3d at 1284; *Levinson*, 245 F.3d at 1327; *House*, 241 F.3d at 1048; *Pinto*, 214 F.3d at 393-94; *Zavora*, 145 F.3d at 1123; *Woo*, 144 F.3d at 1162; *Donaho*, 74 F.3d at 901. This Court has also recently acknowledged that ERISA insurers may not refuse to credit an insured's reliable evidence of disability, including the opinions of the insured's treating physicians. *The Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003).

The abuse of discretion standard of review does not require abject or absolute deference to the ERISA insurer's

decision; it is not a rubber stamp of approval. *McDonald*, 347 F.3d at 172; *Hackett v. Xerox Corp. Long Term Disability Income Plan*, 315 F.3d 771, 774-75 (7th Cir. 2003); *Pinto*, 214 F.3d at 393. When an ERISA insurer determines eligibility and also pays the benefits out of its own assets, there is an inherent conflict of interest that decreases the deference accorded the ERISA insurer's decision. *Stup*, 390 F.3d at 307; *Fought*, 379 F.3d at 1003-04, 1006-07; *Caldwell*, 287 F.3d at 1282-83; *Levinson*, 245 F.3d at 1326; *Pinto*, 214 F.3d at 387-94; *Vega v. National Life Insurance Services, Inc.*, 188 F.3d 287, 297-99 (5th Cir. 1999); *Woo*, 144 F.3d at 1161-62. Under the "sliding scale" adopted by the majority of Circuits, this inherent conflict of interest increases the quality and quantity of evidence necessary to support the insurer's decision, as well as the scrutiny that is given to process leading to the insurer's decision. *Stup*, 390 F.3d at 307; *Caldwell*, 287 F.3d at 1282-83; *Pinto*, 214 F.3d at 393-94; *Vega*, 188 F.3d at 297-98; *Woo*, 144 F.3d at 1162.

In the context of a termination of disability benefits that an insurer has been paying to an insured, the Eighth Circuit has recognized the important focus should be on the events that occurred between the insurer's decision to pay the insured disability benefits and the insurer's decision to terminate those benefits, and unless the information provided to the insurer in that time frame alters in some significant way, the previous payment of benefits must weigh against terminating those benefits. *McOsker v. Paul Revere Life Insurance Company*, 279 F.3d 586, 590 (8th Cir. 2002).

The Sixth Circuit has also determined that a conflicted ERISA insurer abused its discretion when it terminated LTD benefits it was paying an insured, because there was no change in the medical evidence in the administrative record

that initially justified payment of the LTD benefits. *McDonald*, 347 F.3d at 163-64, 166, 169-73. In *McDonald*, the Sixth Circuit found a report of an insurer's retained psychiatrist that only raised the possibility of returning to work was not substantial evidence the insured was no longer disabled. 347 F.3d at 170-71.

In a case involving chronic fatigue syndrome and fibromyalgia, the First Circuit has held that Liberty Life abused its discretion when it terminated LTD benefits after paying them to an insured for over three years, because the medical evidence supplied by the insured's physician continued to show she remained disabled, as a consequence of fibromyalgia, and there was no credible contrary medical evidence in the administrative record that supported Liberty Life's termination of her LTD benefits.[3] *Cook*, 320 F.3d at 14, 16, 17, 21-23. In *Cook*, the First Circuit found that Liberty Life's about-face was not justified by its exaggeration of the significance of a confused communication of the insured's treating physician, an unjustified demand for "objective medical evidence", and its reliance on sketchy information of part-time work. 320 F.3d at 23.

In *Stup*, the Fourth Circuit held that a conflicted ERISA insurer must have more than tentative and ambiguous evidence that might or might not support its termination of disability benefits it had been paying to an insured. 390 F.3d

[3] The First Circuit also noted that Cook qualified for disability benefits from the Social Security Administration for her fibromyalgia just before Liberty Life terminated her LTD benefits. *Cook*, 320 F.3d at 16, n.5. As is reflected in the District Court's Supplement to Memorandum Opinion and Order, Ellis also began receiving SSA disability benefits shortly after Liberty Life denied her administrative appeal. (App. C, *infra*, at p. 49a).

at 309. The Fourth Circuit affirmed a district court's finding the insurer abused its discretion when it terminated LTD benefits it had been paying the insured for just over two years on the basis of an equivocal FCE that did not demonstrate the insured could perform sedentary work on an eight hour a day, five day a week basis. *Stup*, 390 F.3d at 309. The equivocal opinions of the physical therapist who performed the FCE and the insurer's in-house physician were not "substantial evidence" that supported termination of the LTD benefits. *Stup*, 390 F.3d at 309-11.

In another case involving fibromyalgia, the Third Circuit reversed a judgment approving a termination of LTD benefits an ERISA insurer had been paying to the insured for over three years. *Kosiba*, 384 F.3d at 61-63, 68-69. The evidence in the administrative record demonstrated considerable medical evidence from the insured's treating physicians that she remained disabled due to fibromyalgia, as well as a determination by the Social Security Administration that she was disabled on the basis of fibromyalgia. *Kosiba*, 384 F.3d at 68-69. The only contrary medical evidence was the report of a pulmonologist hired by the plan who did not address the insured's fibromyalgia and was not qualified to do so. *Id.*

In *Pinto*, the Third Circuit determined there was a fact issue whether a conflicted ERISA insurer abused its discretion when it terminated LTD benefits it was paying an insured, because there was: (1) no additional medical evidence supporting a reversal of its initial determination of disability; (2) the insurer selectively considered certain limitations from the treating cardiologist's records but disregarded his conclusions about disability; and (3) the insurer refused to accept a determination by the SSA the insured was disabled when it had used a previous SSA denial

as a basis for further investigation. 214 F.3d at 379-80, 393-94. In reversing the summary judgment granted in favor of the insurer, the Third Circuit remarked:

> First, Reliance Standard's reversal of its initial decision to grant benefits itself was questionable. Second, its final report credited the evidence favorable to the denial while inadequately explaining why it rejected the contrary evidence-the same evidence on the basis of which it had initially determined to award benefits.

Pinto, 214 F.3d at 379. This is practically the same criticism that Judge Pickering raised in his dissent concerning the deficiency in the panel majority's rendition of judgment in favor of Liberty Life. (App. A, *infra*, at pp. 31a-32a).

The Fifth Circuit's majority opinion clearly conflicts with the well-recognized substantial evidence requirement under the ERISA abuse of discretion standard of review. Despite a complete absence of credible evidence in the administrative record that Ellis could perform all of the material and substantial duties of her occupation, the panel of the Fifth Circuit summarily concluded Liberty Life's decision to terminate Ellis' LTD benefits eight months after it had begun paying them to her was not an abuse of discretion and rendered judgment in favor of Liberty Life.

The only support the panel cites in its majority opinion is a vague statement that Liberty Life "acquired subsequent medical evidence" after it had approved Ellis' entitlement to those LTD benefits. (App. A, *infra*, at p. 20a). The panel cites no specific evidence that supports the termination decision, and its silence can only be construed as an abject

deference that is certainly not permissible, given Liberty Life's admitted conflict of interest. (App. A, *infra*, at p. 12a).

However, as is detailed in the District Court's Memorandum Opinion and Order, there was "no credible, substantial, or positive evidence" in the administrative record that supported Liberty Life's abrupt about- face. Instead, the evidence in the administrative record from Drs. Hayes, Fujii, Matwijiw and Popovich all supported findings that Ellis suffered from an inflammatory myopathy, fibromyalgia, that resulted in chronic, severe musculoskeletal pain, fatigue, and cognitive impairments. This disease prevented Ellis from performing on the job driving, standing for any length of time, lifting more than 10 pounds on occasion, climbing, reaching, pulling, performing fine finger dexterity, or working an eight hour day. In fact, her condition was not improving but was getting progressively worse at the time her LTD benefits were terminated. (App. B, *infra*, at pp. 39a-41a, 47a).

The only other evidence in the administrative record came from the neurologist Liberty Life hired to examine Ellis, Dr. Croft. Dr. Croft was unsure of the specific diagnosis for Ellis' condition, it was possibly fibromyalgia or polymyocitis; and he did not address whether she could perform any duty of her occupation, except sitting. Indeed, he did not even state whether Ellis could perform any of the material or critical duties of her occupation, only that there was "insufficient evidence" that she could not perform a sedentary job. (App. B, *infra*, at p. 45a). Dr. Croft's "report" is hardly the quality or quantity of "substantial evidence" that is required in these circumstances by the vast majority of the Circuits, particularly the First, Third, Fourth, Sixth and Eighth Circuits.

The panel majority's vague reference to "subsequent medical evidence" also appears to allow Liberty Life to refuse to credit Ellis' considerable, if not overwhelming, reliable evidence of disability, contrary to this Court's admonition in *Nord*. Certainly, there is no discussion in the panel's majority opinion that gives any credit to the considerable medical evidence provided by Ellis' treating physicians or the factual information Ellis provided. Although the Social Security Administration gave this same evidence considerable weight in determining Ellis was disabled from any gainful employment, the majority of the Fifth Circuit panel apparently ignored it, just as Liberty Life did when it terminated Ellis' LTD benefits. Thus, there is no way the Fifth Circuit's rendition of judgment in favor of Liberty Life can be squared with *Nord*. This Court should also review this case to address this apparent disregard of its opinion regarding the ERISA abuse of discretion standard of review.

In reversing the District Court's judgment and rendering judgment for Liberty Life, the Fifth Circuit panel's majority ignores established federal law and renders an opinion that directly conflicts with the vast majority of the Circuits, particularly the First, Third, Fourth, Sixth and Eighth Circuits regarding the ERISA abuse of discretion standard of review. This rendition of judgment in favor of Liberty Life in these circumstances is also contrary to this Court's opinion in *Nord*. The ERISA abuse of discretion standard of review and its requirements are an important and recurring subject in ERISA benefits litigation. This Court should review this case to resolve the conflict between the established federal law on this subject and the Fifth Circuit's determination that Liberty Life is entitled to judgment, even though there is no substantial concrete evidence that supports its termination of Ellis' LTD benefits.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT FILED NOVEMBER 19, 2004

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 03-20623

LINDA ELLIS,

Plaintiff - Appellee - Cross-Appellant,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON,

Defendant - Appellant - Cross-Appellee.

Appeal from the United States District Court for the Southern District of Texas

Before JOLLY, WIENER, and PICKERING, Circuit Judges.*

WIENER, Circuit Judge:

Defendant-Appellant-Cross-Appellee Liberty Life Assurance Company of Boston ("Liberty") appeals the district court's denial of its motion for summary judgment and that court's grant of summary judgment in favor of plaintiff-appellee-cross-appellant Linda Ellis ("Ellis"). The

* Judge Pickering, whose dissent follows, participated in the original panel process before he resigned.

district court concluded that no genuine issue of material fact existed as to Ellis's claim under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and that she was entitled to summary judgment. The court ultimately ruled that Liberty in its role as plan fiduciary abused its discretion when it terminated Ellis's long-term disability ("LTD") benefits because substantial evidence did not demonstrate a change in her medical condition after Liberty initially determined that Ellis qualified for LTD benefits. The district court dismissed Ellis's state-law claims, however, holding that they are preempted by ERISA; and Ellis cross-appeals that ruling. For the reasons that follow, we (1) affirm the district court's dismissal of Ellis's state-law claims, (2) reverse the district court's grant of summary judgment and award of costs and fees in favor of Ellis, and (3) grant summary judgment in favor of Liberty, rendering a take-nothing judgment on Ellis's ERISA claim.

I. FACTS AND PROCEEDINGS

A. *The Policy*

Liberty is a nationwide insurance carrier that issued a disability insurance policy ("the Policy") to Chase Manhattan Bank ("Chase") in January 1997. The Policy, which is an integral part of an employee welfare benefits plan governed by ERISA, provides LTD benefits to eligible Chase employees.

The Policy specifies that LTD benefits are payable for the first 24 months of disability to a covered employee who is "*unable to perform all* of the material and substantial *duties*

of his occupation on an Active Employment basis because of an Injury or Sickness."[1] The Policy further provides that after 24 months, LTD benefits continue to be payable if the disabled employee "is unable to perform *with reasonable continuity,* all of the material and substantial *duties of his own or any other occupation* for which he is or becomes reasonably fitted by training, education, experience, age and physical and mental capacity."[2] As the plan fiduciary, Liberty is expressly vested with discretionary authority to make all coverage, eligibility, and interpretation decisions with regard to the Policy: "Liberty shall possess the authority, in its sole discretion, to construe the terms of this policy and to determine benefit eligibility hereunder."[3]

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1. Emphasis added.

2. Emphasis added.

3. Liberty urges that it is not the "plan administrator" as defined in 29 U.S.C. § 1002(16)(A), but the "claims administrator" or "claims fiduciary," as defined in 29 U.S.C. § 1105(c). Although our standard of review could hinge on which title is applicable to Liberty, independent research satisfies us that Liberty is a "fiduciary" as defined under 29 U.S.C. § 1002(21)(A) and thus entitled to the deferential "abuse of discretion" standard of review, irrespective of whether it is the plan administrator, claims administrator, or plan fiduciary.

Another thorough review of the plan reveals no specific designation of a "plan administrator." Chase, however, is specifically designated as the "plan sponsor." Thus, under the ERISA'S default provision, Chase is also the plan administrator. *See* 29 U.S.C. § 1002(16)(A)(ii) ("The term 'administrator' means . . . if an

(Cont'd)

Appendix A

B. *Ellis's Claim*

In 1997, Chase hired Ellis as a mortgage loan officer. Ellis worked at Chase until 1999, when she applied for short-term disability ("STD") benefits—under a different Liberty policy—because she could no longer perform her job duties as a loan officer. Although the exact nature of Ellis's medical condition remains somewhat unclear from the evidence in the record on appeal, her medical records indicate that she

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(Cont'd)
administrator is not so designated, the plan sponsor . . ."). Contrary to Liberty's assertion, though, we cannot conclude that it is the "claims administrator" under Section 1105(c) because in neither the plan nor any other document in the record does Chase expressly delegate any authority to Liberty (regrettably, the record does not contain *inter alia*, the Summary Plan Description). *See* 29 U.S.C. § 1105(c)(1) (stating that the plan may "expressly" provide for procedures allocating fiduciary responsibilities). Thus, without more, we would be required to review Liberty's interpretation of the plan *de novo*. *See, e.g., Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580, 584 (1st Cir. 1993) (holding that because there was no express delegation of fiduciary duty in plan documents to person or entity who made termination of benefits decision, district court correctly applied *de novo* standard of review); *Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279, 1283- 84 (9th Cir. 1990) (same).

Nevertheless, we conclude—and there is no dispute—that Liberty is a "fiduciary" under 29 U.S.C. § 1002(21)(A) because Liberty is vested with "discretionary authority or discretionary responsibility in the administration of [the] plan." *See* 29 U.S.C. § 1002(21)(A)(iii). Accordingly, because Liberty is a fiduciary that the plan vests with discretionary authority, we review Liberty's determinations under the abuse of discretion standard. *See Baker v. Metro. Life Ins. Co.*, 364 F.3d 624, 629-30 & n.12 (5th Cir. 2004).

might suffer from fibromyalgia, a rheumatic syndrome that causes pain in muscles, tendons, and fibrous and other connective tissues. Liberty reviewed Ellis's STD claim, approved it, and started paying her STD benefits in January 2000.[4]

When Ellis's STD benefits expired later that year, her claim automatically converted into one for LTD benefits under the Policy. Liberty then began to investigate whether Ellis's claim fell within the Policy's definition of LTD. In June 2000, Liberty informed Ellis by letter that it had reviewed her file and determined that she was eligible for LTD benefits. Liberty also informed Ellis that it would periodically require updated medical information "to support total disability as defined by the Policy." Liberty continued its investigation, and, in light of additional medical evidence that it subsequently gathered, Liberty determined that Ellis was not eligible for LTD benefits. In December, Liberty wrote to Ellis:

> While it is apparent you were ill and met the criteria for your policy's definition of disability initially, based on the medical information received, you no longer meet your Long Term Disability Policy's definition of disability. Therefore, we must close your claim for benefits, effective December 31, 2000.

The following month, Ellis administratively appealed Liberty's decision to terminate her LTD benefits. Ellis

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4. Liberty's grant of STD benefits to Ellis for the maximum period of six months is not before us on appeal.

submitted further medical information to Liberty, which forwarded her file to its Managed Disability Services Unit ("MDSU"). The MDSU concluded that no objective medical findings existed that would render Ellis "disabled" within the contemplation of the Policy. Liberty then affirmed its decision to terminate Ellis's LTD benefits. (Liberty has made no effort, however, to recoup the LTD benefits previously paid to Ellis.)

In October, Ellis sued Liberty in Harris County, Texas. Ellis asserted Texas statutory and common law claims for violations of the state insurance code, breach of contract, and breach of the duty of good faith and fair dealing. Liberty timely removed the suit to the district court pursuant to 28 U.S.C. § 1441(b) on the basis of ERISA preemption.

The following fall, after the close of discovery, Liberty filed a motion for summary judgment seeking dismissal of Ellis's state-law claims. In response, Ellis filed a cross-motion for summary judgment and sought to amend her complaint to state an ERISA claim. The district court granted Ellis leave to amend her complaint, and Liberty filed a supplemental motion for summary judgment to dismiss her ERISA claim.

The district court eventually denied Liberty's motion for summary judgment and granted summary judgment to Ellis on her ERISA claim. The court dismissed Ellis's state-law claims, however, holding that they were preempted by ERISA. The district court subsequently issued a supplemental memorandum and order clarifying its award of attorneys' fees and prejudgment interest to Ellis, ultimately entering final judgment in favor of Ellis.

Two days later, Ellis filed a motion to alter or amend the judgment on the amount of damages, attorneys' fees, and prejudgment interest. The district court granted the motion in part, increasing the quantum of Ellis's future disability benefits and clarifying the rate of prejudgment interest. Liberty timely filed its notice of appeal.[5]

II. ANALYSIS

A. *Leave to Amend Complaint*

Liberty first argues that the district court erred when it granted Ellis leave to amend her complaint to state an ERISA claim. We review a district court's decision to grant leave to amend a complaint for abuse of discretion.[6] Federal Rule of Civil Procedure 15 states that leave to amend pleadings "shall be freely given when justice so requires."[7] In determining whether to grant leave, a district court may consider such factors as (1) undue delay; (2) bad faith; (3) dilatory motive on the part of the movant; (4) repeated failure to cure deficiencies by any previously allowed amendment; (5) undue

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5. On June 16, 2003, Liberty had prematurely appealed the district court's order of June 3, 2003, which granted Ellis's motion for summary judgment. The parties do not dispute that we have jurisdiction because the appeal is now timely. *See* Fed. R.App. P. 4(a)(2) ("A notice of appeal filed after the court announces a decision or order—but before the entry of the judgment or order—is treated as filed on the date of and after the entry.").

6. *Wimm v. Jack Eckerd Corp.*, 3 F.3d 137, 139 (5th Cir.1993).

7. Fed.R.Civ.P. 15.

prejudice to the opposing party; and (6) futility of amendment.[8] Although the district court assigned no reasons on the record for granting Ellis leave to amend her complaint, we are satisfied that it did not abuse its discretion when it did so.

Although Liberty argues that Ellis's amendment demonstrates undue delay, bad faith, and dilatory motive, we find no evidence in the record to support such an argument. Liberty's strongest argument concerns the potential prejudice that it may have suffered as a result of Ellis's filing of her amendment so late in the proceedings in district court. We reject this argument. Liberty removed Ellis's state-court suit on the basis of ERISA preemption. Ultimately, and as Liberty argued in its Notice of Removal, the district court concluded that ERISA preempted all of Ellis's state-law claims.[9] We have previously held that "ERISA's preemptive and civil enforcement provisions operate to 'recharacterize' such claims into actions arising under federal law."[10] Thus, for removal purposes, ERISA's preemptive power recharacterized Ellis's state-law breach of contract claim as a claim arising under federal law, specifically ERISA. Liberty might not have known with certainty that Ellis's breach of

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8. *Wimm*, 3 F.3d at 139.

9. It is unclear whether the district court ruled that ERISA preempted Ellis's state-law claims through complete or conflict preemption. Here, we assume that the district court found that ERISA completely preempted only Ellis's breach of contract claim for removal purposes. *See infra*, note 26.

10. *Degan v. Ford Motor Co.*, 869 F.2d 889, 893 (5th Cir.1989).

contract claim would be recharacterized as an ERISA claim and that Liberty would ultimately have to litigate such a claim. Having removed on the basis of ERISA preemption, however, Liberty cannot now be heard to complain about the district court's grant of leave for Ellis to amend her complaint to include an ERISA claim. There was no prejudice to Liberty, and the district court did not abuse its discretion when it granted Ellis leave to amend her complaint to state an ERISA claim.

B. *ERISA Claim*

1. Standard of Review

We review a district court's grant of summary judgment *de novo*.[11] "Whether the district court employed the appropriate standard in reviewing an eligibility determination made by an ERISA plan administrator is a question of law."[12] We thus review this decision *de novo*.[13] When the ERISA plan vests the fiduciary with discretionary authority to determine eligibility for benefits under the plan or to interpret the plan's provisions, "our standard of review is abuse of discretion."[14] As the Policy vests Liberty, as plan fiduciary,

11. *Tolson v. Avondale Indus., Inc.*, 141 F.3d 604, 608 (5th Cir.1998) (citing *FDIC v. Myers*, 955 F.2d 348, 349 (5th Cir.1992)).

12. *Lynd v. Reliance Standard Life Ins. Co.*, 94 F.3d 979, 980-81 (5th Cir.1996) (citing *Chevron Chem. Co. v. Oil, Chem. & Atomic Workers Local Union 4-447*, 47 F.3d 139, 142 (5th Cir.1995)).

13. *See id.* at 981.

14. *Tolson*, 141 F.3d at 608.

with the "sole discretion" to construe the terms of and to award benefits under the Policy, we review Liberty's interpretation of the Policy for abuse of discretion.[15]

2. Plan Interpretation

We have previously explained in detail the appropriate two-step process to review a plan fiduciary's interpretation of its plan:

> First, a court must determine the legally correct interpretation of the plan. If the administrator did not give the plan the legally correct interpretation, the court must then determine whether the administrator's decision was an abuse of discretion. In answering the first question, i.e., whether the administrator's interpretation of the plan was legally correct, a court must consider:
>
> (1) whether the administrator has given the plan a uniform construction,
>
> (2) whether the interpretation is consistent with a fair reading of the plan, and

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15. When the ERISA plan fiduciary is vested with discretionary authority under the plan, our standard of review is the same as if the fiduciary were the plan administrator under 29 U.S.C. § 1002. *See, e.g.*, *Estate of Bratton v. Nat'l Union Fire Ins Co. of Pittsburgh*, 215 F.3d 516, 520-21 (5th Cir. 200) (noting that same standard of review applies to plan administrators and fiduciaries).

> (3) any unanticipated costs resulting from different interpretations of the plan.[16]

If we determine that the fiduciary's interpretation of the plan was legally correct, the inquiry is over, pretermitting any need to consider whether a legally incorrect interpretation of the fiduciary was not an abuse of discretion.[17]

We have also held that when a complaining participant or beneficiary shows that the plan fiduciary has a conflict of interest, we apply a sliding scale to the *Wildbur* standard: "The greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be."[18] "The degree to which a court must abrogate its deference to the administrator depends on the

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16. *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 637-38 (5th Cir.), *modified*, 979 F.2d 1013 (1992).

17. *See id.; see also Tolson*, 141 F.3d at 608 ("A determination that a plan administrator's interpretation is legally correct pretermits the possibility of abuse of discretion.").

18. *Vega v. National Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir.1999) (en banc) (discussing *Wildbur*).

Unlike the dissent, we will not read into *Vega* a presumption that a conflict exists *ipso facto* merely because the plan fiduciary both insures the plan and administers it. *See MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 479 n. 8 (5th Cir.2003). That an ERISA plaintiff must come forward with evidence that a conflict exists—and that any reduction in the degree of our deference depends on such evidence—belies any duty on our part to make such an assumption. *See id.*

extent to which the challenging party has succeeded in substantiating its claims that there is a conflict."[19] In its Objections and Responses to Plaintiff's Request for Admissions, Liberty acknowledges that it has a financial interest in the dollar value of the claims that are paid under the Policy. This is enough to satisfy us that a legal conflict of interest exists here. Accordingly, we apply the sliding-scale standard of review articulated in *Vega* to Liberty's interpretation of its Policy provision.

As noted above, the LTD Policy provides that benefits are initially payable only to an employee who is "unable to perform *all* of the material and substantial *duties of his occupation* on an Active Employment basis because of an Injury or Sickness."[20] The district court concluded that, under this language, Ellis would be eligible to receive LTD benefits if she "could not perform *any one* of the material duties of her occupation."[21]

The district court erred when it interpreted the phrase "unable to perform *all*"—the language in the policy—as synonymous with "unable to perform *any one*." We interpret "unable to perform all" as synonymous with "not able to perform every." In other words, "unable" is synonymous with "not able," and "all" is synonymous with "every." Applying the *Wildbur* methodology, we hold that Liberty gave a legally correct interpretation to this provision of the plan.

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19. *MacLachlan*, 350 F.3d at 479.

20. Emphasis added.

21. Emphasis added.

Appendix A

The first *Wildbur* factor—whether the fiduciary has given the plan a uniform construction—weighs in favor of Liberty's interpretation. The district court mistakenly relied solely on the deposition testimony of Liberty's litigation manager, Paula McGee, as support for crediting Ellis's proffered interpretation that she is entitled to LTD benefits if she is unable to perform "any one" of the material and substantial duties of her occupation. McGee testified:

> Q. Under that definition, if Ms. Ellis could not perform one of the material duties of her occupation, she would be disabled?
>
> A. Yes.

In a subsequent affidavit, however, McGee explained that counsel's question at the deposition confused her and that the company had consistently interpreted "Disability" to mean a person who is unable—not able—to perform all—each and every one—of the material and substantial duties of her own occupation:

> Liberty has consistently interpreted the Policy. Specifically, when evidence reveals that during the first 24 months of disability, an employee is capable of performing the material and substantial duties of her own occupation, the Company has denied benefits. In my five years of employment with Liberty, I cannot recall an instance where this Policy provision was interpreted differently.

Appendix A

McGee's post-deposition affidavit is buttressed by the testimony of Liberty's disability claims consultant and its appeals consultant. Both testified in depositions that Liberty decided to terminate Ellis's benefits by virtue of its interpretation that a disabled person under the LTD Policy is a person who is not able to perform every material and substantial duty of her occupation. All this tips the scale in favor of Liberty on the first *Wildbur* factor.

The next *Wildbur* factor—whether Liberty's interpretation is "consistent with a fair reading of the plan"—also supports Liberty's interpretation. For Ellis to qualify for LTD benefits under the Policy, Liberty determined that she had to show that she could not perform "each" of the material and substantial duties of her occupation; in other words, "each and every duty" or "every single duty." This is consistent with a fair reading of the plain wording of the plan. There is no dispute that the Policy language requires that Ellis be unable to perform *all* of the material and substantial duties of her occupation to receive LTD benefits. We conclude that in the context of the Policy as a whole, a fair reading of the term "unable to perform all" is that Ellis is *not* disabled for purposes of LTD if she *can* perform "at least one" of the material and substantial duties of her occupation. Ellis's proffered interpretation, that she *is* disabled if she *cannot* perform one ("any one") of the material and substantial duties of her occupation—i.e., "unable to perform all" means "not able to perform any one"—cannot be squared with the Policy's language.

Our conclusion that Liberty's interpretation is legally correct is strengthened by consideration of the third *Wildbur*

factor—whether a different interpretation of the plan would result in unanticipated costs to the plan. A comparison of the Policy provisions that define "Disability" and "Partial Disability" *in pari materia* leads inescapably to the conclusion that adoption of Ellis's proffered interpretation would lead to Liberty's incurring of unanticipated costs. Section 4 of the Policy defines *Partial* Disability:

> "Partial Disability" or "Partially Disabled" means as a result of the Injury or Sickness, the Covered Person is: 1. able to perform *one or more, but not all,* of the material and substantial duties of his own or any other occupation on an Active Employment or a part-time basis . . .[22]

Liberty reasons with irrefutable logic that if we were to credit Ellis's interpretation of "Disability," the definitions of "Disability" and "Partial Disability" would conflate these separate categories into one, i.e., there would be no difference between the eligibility prerequisites for *total* disability and those for *partial* disability. It follows that if that were the case, Liberty would be required to provide both LTD and partial disability benefits to a covered employee if he could not perform "any one" of the material and substantial duties of his occupation, a patently absurd result. If the definition of long term disability were interpreted to mean "unable to perform just one," as Ellis urges, "unable to perform all" in the definition of *Disability* would be synonymous with "unable to perform one or more" in the definition of *Partial Disability*. That simply cannot be: Such a reading would

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22. Emphasis added.

render partial disability's phrase "but not all" meaningless surplusage, not to mention putting it in direct conflict with Ellis's proffered interpretation of "all" in the phrase "unable to perform all" in the definition of Disability. Obviously, this cannot be the intended result under the Policy and—just as obviously—unanticipated costs would be incurred by Liberty.

Ellis attempts to counter by asserting that Liberty's interpretation is legally incorrect because "[u]nder this contorted interpretation, virtually no person could ever satisfy the definition of 'Disability.'" Ellis offers the example of a secretary who is rendered paraplegic, contending that this employee would not be disabled under Liberty's interpretation if she could sit at her desk in a wheelchair and answer a speaker phone. Ellis's argument ignores, however, the two adjectives that modify "duties"—"material and substantial." Merely because a disabled employee can perform a minor, collateral duty of his job, e.g., answering a speaker phone, would not justify the plan fiduciary's considering such an employee ineligible for benefits under Liberty's interpretation of the LTD Policy. In such a situation, the disabled employee *would be* disabled under Liberty's interpretation, despite his ability to perform minor duties, as long as he could not—was "unable to"—perform any of the *material and substantial* duties of his occupation. We conclude that Ellis would have to demonstrate that she cannot perform "every single" or "each and every" "material and substantial duty of her occupation"—which she could not

prove—to obtain LTD benefits. Liberty gave a legally correct interpretation of the plan provision in question.[23]

Among the rest of Ellis's arguments, we perceive that two merit brief consideration. The first concerns the burden of proof under ERISA. Ellis insists that substantial record

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23. Even if we were to assume, *arguendo,* that Liberty, as a plan fiduciary with a *Vega* conflict, was not legally correct, we would hold that Liberty did not abuse its discretion vested by the Policy, and that Ellis could not recover. To determine whether the plan fiduciary abused its discretion, we consider: (1) the internal consistency of the plan under the fiduciary's interpretation; (2) any appropriate regulations formulated by the appropriate administrative agencies; and (3) the factual background of the determination and any inferences of lack of good faith. *Wildbur,* 974 F.2d at 638.

The first *Wildbur* factor for determining abuse of discretion—the internal consistency of the plan under the plan fiduciary's interpretation—weighs in favor of Liberty's interpretation, as our discussion on the relationship between "Disability" and "Partial Disability" demonstrates. Adoption of Ellis's proffered interpretation would render the language in the "Partial Disability" provision superfluous and inconsistent with that in the "Disability" provision. The second *Wildbur* factor—any relevant administrative agency regulations—is neutral as we have found none that apply here. The third *Wildbur* factor also weighs in favor of Liberty. Although Ellis may urge that Liberty made its decision in bad faith, the fact that Liberty initially granted her LTD benefits under the Policy supports a finding of good faith on Liberty's part. Further, as we note below, merely because Liberty initially granted Ellis benefits, it is not estopped from terminating those benefits when substantial evidence supports its decision. A careful and thorough review of the administrative record eschews a conclusion of abuse of discretion in Liberty's decision to terminate Ellis's benefits.

evidence supports her claim of total disability, in light of which Liberty abused its discretion when it determined that she was not disabled. This argument misapprehends the burden of proof under ERISA. The law requires only that substantial evidence support a plan fiduciary's decisions, including those to deny or to terminate benefits, *not* that substantial evidence (or, for that matter, even a preponderance) exists to support the employee's claim of disability.[24] Substantial evidence is "more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[25] We are aware of no law that requires a district court to rule in favor of an ERISA plaintiff merely because he has supported his claim with substantial evidence, or even with a preponderance. If the plan fiduciary's decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail.

The second argument that we address is more problematic, as it tangentially concerns the degree or level of proof that is needed to sustain a plan fiduciary's interpretation of its policy provision. The crux of the dispute here is whether—as Ellis contends and the district court

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24. *See, e.g., Meditrust Fin. Servs. Corp. v. Sterling Chem., Inc.*, 168 F.3d 211, 215 (5th Cir.1999) ("When reviewing for arbitrary and capricious actions resulting in an abuse of discretion, we affirm an administrator's decision if it is supported by substantial evidence.").

25. *Deters v. Secretary of Health, Educ. & Welfare*, 789 F.2d 1181, 1185 (5th Cir.1986) (citing *Richardson v. Perales*, 402 U.S. 389, 401 (1971)).

ruled—a plan fiduciary's decision to terminate LTD benefits once it has initially agreed to provide them must be supported by evidence that a substantial change in the covered employee's medical condition occurred *after* the initial grant of benefits. The parties dispute whether a higher standard of proof is required to sustain a plan fiduciary's decision to *terminate* benefits once granted than is needed to sustain a plan fiduciary's *initial denial* of benefits. Ellis argues that because Liberty initially determined that she qualified for LTD benefits, it abused its discretion when it terminated her LTD benefits months later, without medical evidence reflecting that a substantial change in her condition had occurred in the interim. The district court accepted Ellis's evidentiary dichotomy and ruled that the absence of credible, substantial, or positive evidence in the record to demonstrate that Ellis had become medically ineligible for permanent disability benefits *after* having been found eligible initially precluded Liberty from terminating the benefits previously granted.[26]

We disagree with the district court's view of the applicable law. We have found no statutory, regulatory, or jurisprudential authority—and neither Ellis nor the district court has cited any to us—that would heighten the level of the proof needed for a plan fiduciary to determine entitlement or non-entitlement to LTD benefits simply because the fiduciary previously had approved entitlement and paid benefits to the employee in question. The district court committed legal error when it concluded that, once the

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26. We note that the district court still reviewed Liberty's interpretation of the LTD Policy provisions for abuse of discretion.

fiduciary approves entitlement to LTD benefits, subsequent termination of those benefits would have to be supported by substantial evidence of a *change in the employee's condition.* We have never articulated such an evidentiary distinction or imposed such a requirement on the plan fiduciary: All that ERISA requires is that substantial evidence support a plan fiduciary's benefits decision—whether it be to deny benefits initially or to terminate benefits previously granted—when, as here, the plan fiduciary is vested with the discretion to determine, *inter alia,* both initial and continued eligibility for benefits. In the investigation that continued following its initial grant of LTD benefits to Ellis, Liberty acquired subsequent medical evidence that supported termination of her LTD benefits months *after* it had approved Ellis's entitlement to them on the basis of the evidence that it had before it at that time.

We hold that when a plan fiduciary initially determines that a covered employee is eligible for benefits and later determines that the employee is not, *or has ceased to be,* eligible for those benefits by virtue of additional medical information received, the plan fiduciary is not required to obtain proof that a substantial change in the LTD recipient's medical condition occurred *after* the initial determination of eligibility. Indeed, evidence could exist—as it did here—at the time that the plan fiduciary initially granted benefits that demonstrates that the ERISA plaintiff is not totally disabled. In addition, a plan fiduciary could receive evidence that an ERISA plaintiff is not totally disabled months after it has made the initial grant of benefits. A contrary holding would basically prohibit a plan fiduciary from ever terminating benefits if it later discovered evidence that the ERISA

plaintiff was not disabled at the time of the initial grant of benefits.[27] More importantly to plan participants and beneficiaries, such a rule would have a chilling effect on the promptness of granting initial benefits in the first place. This we are unwilling to do. A plan fiduciary that has granted plan benefits to a participant or beneficiary is not estopped from terminating those benefits merely because there is no evidence that a substantial change in the covered employee's medical condition occurred after the original grant of benefits.

3. Attorneys' Fees and Costs

As we reverse the district court's grant of summary judgment in favor of Ellis, we vacate the award of costs and attorneys' fees to Ellis.

4. Preemption

Ellis cross-appeals the district court's ruling that ERISA preempts her state-law claims. She sued Liberty for violations of Texas Insurance Code ("TIC") articles 21.21 and 21.55 and for breaches of the common law duty of good faith and fair dealing. TIC article 21.21 prohibits unfair competition and unfair practices by insurance companies and subjects them to civil liability for violations.[28] TIC article 21.55 subjects insurance companies to civil liability if they unfairly

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27. This is especially true in a case such as this, where some of the evidence on which Liberty relied to deny LTD benefits to Ellis arose in May and June 2000, before it initially granted her LTD benefits.

28. *See* TEX. INS. CODE § 21.21.

and untimely process and treat a claim.[29] With respect to Ellis's common-law claim, the courts of Texas have held that "[a] cause of action for breach of the duty of good faith and fair dealing is stated when it is alleged that there is no reasonable basis for denial of a claim or delay in payment or a failure on the part of the insurer to determine whether there is any reasonable basis for the denial or delay."[30] Ellis argues that the United States Supreme Court's holding in *Kentucky Association of Health Plans, Inc. v. Miller*[31] brings her claims under ERISA's savings clause.[32] We review ERISA preemption of state law *de novo*.[33]

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29. *See* TEX. INS. CODE § 21.55.

30. *Arnold v. Nat'l County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex.1987).

31. 538 U.S. 329, 341-42 (2003).

32. 29 U.S.C. § 1144(b)(2)(B) ("Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.").

33. *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 640 (5th Cir.2004).

Under conflict preemption,[34] ERISA preempts state laws "insofar as they may now or hereafter relate to any employee

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34. There are two types of preemption under ERISA. ERISA may occupy a particular field, which results in complete preemption under 29 U.S.C. § 1132(a). *See Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 66 (1987). "Section 502 [1132(a)], by providing a civil enforcement cause of action, completely preempts any state cause of action seeking the same relief, regardless of how artfully pleaded as a state action." *Giles v. NYLCare Health Plans, Inc.,* 172 F.3d 332, 337 (5th Cir.1999). Complete preemption permits removal to federal court because the cause of action arises under federal law. *See id.* The parties do not dispute, and the district court properly concluded, that for purposes of removal, Ellis's state law breach of contract claim arose under federal law because it is one for the recovery of benefits under Section 1132(a). *See Arana v. Ochsner Health Plan,* 338 F.3d 433, 438 (5th Cir.2003) (en banc) (noting that a claim "to recover benefits . . . under the terms of [a] plan" or a claim "to enforce . . . rights under the terms of [a] plan" is completely preempted under Section 1132(a)). Accordingly, the district court properly exercised supplemental jurisdiction over Ellis's remaining state-law claims under 28 U.S.C. § 1367. *See Darcangelo v. Verizon Communications, Inc.,* 292 F.3d 181, 187 (4th Cir.2002).

In contrast, ERISA preempts a state law action under 29 U.S.C. § 1144(a) when it conflicts with the state law. *Bullock v. Equitable Life Assur. Soc. of U.S.,* 259 F.3d 395, 399 (5th Cir.2001). Conflict preemption does not allow removal to federal court but is an affirmative defense against claims that are not completely preempted under Section 1132(a). *Giles,* 172 F.3d at 337. We assume for purposes of this appeal, and because the parties dispute *Miller*'s applicability to the claims here, that the district court found that Ellis's three remaining state-law claims were preempted under Section 1144(a), ERISA's conflict preemption provision. We therefore do not consider whether Section 1132(a) *completely* preempts Ellis's state-law claims.

benefit plan."[35] As an exception, however, ERISA's so-called savings clause allows state laws "which regulate insurance, banking, or securities" to survive ERISA preemption.[36] In *Miller,* the Supreme Court simplified the test for ERISA conflict preemption when it made a clean break with the McCarran-Ferguson factors that it traditionally applied to determine whether a state statute regulated insurance and thus survived preemption under ERISA's saving clause.[37] After *Miller,* for a state law to be deemed a "law . . . which regulates insurance" under Section 1144(b)(2)(A) and thus be exempt from traditional ERISA preemption, such law must (1) be directed toward entities engaged in insurance, and (2) substantially affect the risk pooling arrangement between the insurer and the insured.[38]

On the one occasion that we considered *Miller*'s change to ERISA preemption, we observed that "[t]he only pertinent difference between the *Miller* analysis and the previous test is that in place of the second *Miller* inquiry, the previous test asked whether the statute in question 'transfers or spreads

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35. 29 U.S.C. § 1144(a).

36. *Id.* § 1144(b)(2)(A).

37. 538 U.S. at 339. Under the McCarran-Ferguson factors, the Court considered whether (1) the practice had the effect of transferring or spreading a policyholder's risk; (2) the practice is an integral part of the policy relationship between the insured and the insurer; and (3) whether the practice is limited to entities within the insurance industry. *See id.*

38. *Id.* at 341-42.

the risk from the insured to the insurer.'"[39] Also, prior to *Miller,* we held that ERISA preempts TIC articles 21.21[40] and 21.55[41] well as the Texas common law duties of good faith and fair dealing.[42] Thus, we need only answer whether the "simplified" *Miller* analysis affects our prior holdings. We conclude that it does not with respect to Ellis's state-law claims. Thus, ERISA preempts Ellis's common law claim for breach of the duties of good faith and fair dealing. Specifically, this common law doctrine fails the first prong of the *Miller* analysis because it is not directed toward entities engaged in insurance.[43]

Regarding Ellis's two statutory claims, Liberty contends that TIC articles 21.21 and 21.55 likewise fail the first prong of the *Miller* analysis because they address the misconduct of insurers and thus do not regulate insurance. This argument misses the mark. As the Supreme Court noted in *Rush Prudential v. Moran,* to determine whether a law "regulates insurance," "we start with a 'common-sense view of the

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39. *Sharpless,* 364 F.3d at 640.

40. *Hogan v. Kraft Foods,* 969 F.2d 142, 144-45 (5th Cir.1992) (and cases cited therein).

41. *McNeil v. Time Ins. Co.,* 205 F.3d 179, 191-92 (5th Cir.2000).

42. *Hogan,* 969 F.2d at 144-45 (and cases cited therein).

43. *See Miller,* 538 U.S. at 334, 123 S.Ct. 1471 ("[L]aws of general application that have some bearing on insurers do not qualify.").

matter,' . . . under which 'a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.'"[44] In *Moran,* the Supreme Court went on to hold that "when insurers are regulated with respect to their insurance practices, the state law survives ERISA."[45] In *Sharpless,* we analyzed the effect of the *Miller* decision on our ERISA preemption analysis, noting that *Miller* had not changed this factor.[46] Indeed, whereas the McCarran-Ferguson analysis required that we determine whether the practice "is limited to *entities* within the insurance industry,"[47] the *Miller* analysis merely requires that we determine whether the "statute is specifically directed towards *entities* engaged in insurance."[48] TIC articles 21.21 and 21.55 are undeniably directed toward *entities* engaged in insurance, as they regulate any possible unfair practices and expose the insurer to civil liability for violations of the statutes. We are satisfied therefore that articles 21.21 and 21.55 satisfy the first prong of the *Miller* analysis.

To survive ERISA preemption, however, TIC articles 21.21 and 21.55 must also satisfy *Miller*'s second prong; they must "substantially affect the risk pooling arrangement

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44. 536 U.S. 355, 365-66 (2002) (quoting *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 50 (1999)).

45. *Id.* at 366.

46. 364 F.3d at 640.

47. *Id.* at 640 n. 4 (emphasis added).

48. *Id.* at 640 (emphasis added).

between the insurer and the insured."[49] We hold that these two articles do not.

In *Miller,* the Supreme Court explained that, to affect the risk-pooling arrangement, a statute must "alter the scope of permissible bargains between insurers and insureds" and thus substantially affect the risk-pooling "arrangements that insurers may offer."[50] TIC articles 21.21 and 21.55 are remedial in nature—they provide remedies "to which the insured may turn when injured by the bad faith of the insurer."[51] Being remedial, these two articles cannot possibly affect the *bargain* that an insurer makes with its insured *ab initio.* They provide only that "whatever the bargain struck," the insured may recover additional damages if thereafter the insurer acts in bad faith or unfairly.[52] As TIC articles 21.21 and 21.55 provide remedies above and beyond those provided in ERISA, they are remedial in nature and do not affect the

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49. 538 U.S. at 342.

50. 538 U.S. at 338-39.

51. *Barber v. Unum Life Ins. Co. of Am.,* 383 F.3d 134, 143 (3d Cir.2004).

52. *See id.* at 143; *see also Pilot Life,* 481 U.S. at 49-51 (holding that "the common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract may in certain circumstances allow the policyholder to recover punitive damages").

risk—here, the covered employee's disability—for which the insured contracted with the insurer.[53]

Within the insurance industry, "risk" signifies "the risk of occurrence or injury or loss for which the insurer contractually agrees to compensate the insured."[54] Here, the risk pooled is that of long-term disability, and this risk is reflected in the terms of the Policy itself. The remedies that TIC articles 21.21 and 21.55 provide for unfair practices and bad faith are not risks identified in the Policy as a risk of loss that Liberty agrees to bear for Chase or for Ellis and other similarly situated Chase employees. As a basic tenet of insurance law, the insurance policy "defines the scope of risk assumed by the insurer from the insured."[55] Here, Liberty did not contract with Chase or Ellis to assume the risk of any unfair practices or bad faith violations. As TIC articles 21.21 and 21.55 fail *Miller*'s second prong, Ellis's claims grounded in violations of those articles are preempted by ERISA.

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53. *See, e.g.*, TEX. INS. CODE § 21.21(16)(b)(1) (providing treble damages for violations of article 21.21); *Stewart Title Guaranty Co. v. Sterling*, 822 S.W.2d 1, 9 (Tex.1991) (noting that treble damages under article 21.21 are punitive in nature).

Article 21.55 also provides a statutory penalty of 18% interest for an insurance company's failure to comply with its provision. *See Evergreen Nat'l Indem. Co. v. Tan It All, Inc.*, 111 S.W.3d 669, 678 (Tex.App.2003).

54. *Barber*, 383 F.3d at 143.

55. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 131 (1982).

III. CONCLUSION

We affirm the district court's dismissal of Ellis's state-law claims and that court's grant of leave to Ellis to amend her complaint. We reverse the district court's grant of summary judgment and award of costs and fees in favor of Ellis, and we grant summary judgment in favor of Liberty, rendering a take-nothing judgment against Ellis on her ERISA claim.

AFFIRMED IN PART, REVERSED AND RENDERED IN PART.

Appendix A

Pickering, Circuit Judge, dissenting:

I respectfully dissent.

As an initial matter, I disagree with the majority's conclusion that "unable to perform all of the material and substantial duties of his occupation" can only mean unable to perform "each and every one" of the material and substantial duties of an occupation, so that if an employee can perform even one material and substantial duty of his or her occupation, the employee is not disabled. Although this is a reasonable interpretation of the policy language, the policy language is ambiguous and susceptible to more than one reasonable interpretation. I would interpret the policy provision differently. If there are ten material and substantial duties of an occupation and the employee can perform only six of those ten duties, then the employee is by definition "unable to perform *all* of the material and substantial duties" of the occupation. That too is a reasonable interpretation. The ambiguity should be construed against the insurer. *See Wegner v. Standard Ins. Co.*, 129 F.3d 814, 818 (5th Cir.1997). But to construe the policy differently than the administrator would create an internal inconsistency between the policy provisions for total disability and partial disability. Consequently, though I disagree with the majority's interpretation of the policy, this issue is not outcome determinative.

However, I do respectfully dissent from the majority's conclusion that when a plan administrator initially determines that a covered employee is eligible for benefits and later determines that the employee is not eligible for those benefits,

the plan administrator may terminate benefits without demonstrating that its initial decision was erroneous, or without substantial evidence of a change in the claimant's medical condition.

Because this case involves an insurer who is also the plan administrator, producing a direct conflict of interest on the part of the administrator, we apply a sliding-scale standard of deference to the administrator's decision. *See Vega v. Nat'l Life Insur. Servs.*, 188 F.3d 287, 294-99 (5th Cir.1999). Under such circumstances, this court still applies the abuse of discretion standard, "but gives less deference to the administrator in proportion to the administrator's apparent conflict." *Id.* at 296. Where there is a conflicted administrator, "the administrator has a financial incentive to deny the claim and often can find a reason to do so." *Id.* The court must "focus on whether the record adequately supports the administrator's decision." *Id.* at 298. "[W]e are less likely to make forgiving inferences when confronted with a record that arguably does not support the administrator's decision." *Id.* at 299.

At the summary judgment stage, it is the movant who has the burden of showing that there is no genuine issue of material fact. The parties agree that this claim involves a policy of insurance issued by Liberty. Liberty is the administrator. All reasonable inferences are to be drawn in favor of Ellis. If Liberty pays a claim it is not unreasonable to infer that every penny of the claim comes directly out of Liberty's coffers. Any argument that the administrator did not have a direct and total, or almost total conflict of interest in this situation is to ignore reality. The fox guarding the

chicken house is not entitled to great deference.[1] Thus, in analyzing the administrator's decision to terminate benefits, I would give little deference to the administrator's exercise of discretion.

It is undisputed that the administrator initially determined that Ellis was entitled to disability benefits based on the medical evidence, *and later reaffirmed that fact in the letter of termination.* I would hold as a matter of law, that once the administrator determined Ellis was entitled to disability benefits, a subsequent termination of those benefits would be an "arbitrary and capricious" decision by the administrator, and hence an abuse of discretion, unless there is substantial evidence to support *either* (1) that the initial decision to grant benefits was incorrect; or (2) that there has been a change in condition that would justify the termination of benefits. Once the administrator has exercised its discretion and determined that a claimant is entitled to benefits, a later decision to

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1. The majority in a footnote contends that *MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 479 n. 8 (5th Cir.2003), demonstrates that there should be no ipso facto presumption of a conflict. No such presumption is required. The parties admit to the conflict. As this court stated in *MacLachlan:*

> this court's decisions, following *Vega,* that have found an apparent conflict of interest are ones in which a claim was denied by the insurance company that did not employ the claimant, but instead was contractually obligated to make payments under the employer's plan. . . . This is a significant distinction. . . .

Id. at 479 n. 8. This is precisely the factual situation in this case.

terminate those vested disability benefits without justification is by definition arbitrary and capricious and an abuse of discretion. *See Meditrust Financial Servs. v. Sterling Chemicals,* 168 F.3d 211, 215 (5th Cir.1999) (holding that administrator's decision is arbitrary if made without rational connection between known facts and the decision or between found facts and the evidence).

In the termination letter of December 22, 2000, the administrator acknowledged that "it is apparent" that Ellis "met the criteria for [her] policy's definition of disability initially." Thus, in the opinion of the administrator the initial decision to grant disability benefits was correct. The administrator made no effort to show that the initial decision was wrong, but to the contrary, reaffirmed the initial determination. The question then becomes whether there was a change in condition that would justify the later termination of benefits. The majority opinion fails to answer this question.

In the termination letter, the administrator listed (with little explanation of its relevance) the medical evidence used in support of the decision to terminate benefits. The district court analyzed this evidence and found that it did not support the administrator's conclusion to terminate benefits. I agree. I would affirm the district court for basically the same reasons given in the district court's opinion. The record does not adequately support the administrator's decision to terminate benefits because the administrator admitted that the plaintiff was not initially disabled and because there was no substantial evidence of a subsequent change in condition. Thus, the administrator abused its discretion.

Appendix A

The majority contends that the dissent argues that a plan administrator cannot reverse an initial erroneous decision to pay benefits. Contrary to the majority's characterization, I certainly would agree that an insurer can correct an erroneous initial decision to pay benefits, but only if there is substantial evidence to support that decision. But in this case the administrator, Liberty, acknowledged, even in its letter of termination, that the initial determination to award benefits was appropriate.

For the above reasons, I respectfully dissent.

APPENDIX B — MEMORANDUM OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS, HOUSTON DIVISION ENTERED JUNE 3, 2003

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. H-01-3963

LINDA ELLIS,

Plaintiff,

vs.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

Defendant.

MEMORANDUM OPINION AND ORDER

I. INTRODUCTION – PROCEDURAL HISTORY

Before the Court for consideration are the reciprocal motions for summary judgment of the plaintiff and the defendant. The plaintiff, Linda Ellis, seeks to recover against the defendant, Liberty Life Assurance Company of Boston on claims of disability that find bases in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461 *et. seq.*

Appendix B

The plaintiff commenced this suit in state court where she asserted state statutory and common law claims based on violation of the state insurance code, breach of contract, and breach of the duty of good faith and fair dealings. Because the Court finds that the plaintiff's claims arise under a long-term disability benefits policy. The plaintiff's claims are preempted by ERISA and the state law claims asserted are dismissed. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 59 (1987). Pursuant to ERISA's preemption, the defendant caused the plaintiff's suit to be removed to this Court pursuant to 28 U.S.C. § 1441(b). At this time, the Court has reviewed the motions for summary judgment and determines that the plaintiff s summary judgment should be granted and the defendant's motion should be denied.

II. FACTUAL BACKGROUND AND CONTENTIONS

A.

The plaintiff is insured under a disability insurance policy issued and administered by the defendant on behalf of the plaintiffs employer, Chase Manhattan Bank [now J.P. Morgan/Chase]. The plaintiff was first employed with the bank in 1997, where she served as a mortgage loan officer. In 1999, the plaintiff became eligible to receive disability benefits when it was determined that she could no longer perform her duties. After the defendant reviewed the plaintiff's application and claim, benefits were commenced on January 24, 2000. However, on December 22, 2000, the plaintiff received a letter terminating disability benefits.

Appendix B

The plaintiff asserts that the benefits were wrongfully terminated and were terminated without a reasonable stated basis. The plaintiff asserts that her medical condition did not improve during the benefits period and that no evaluation, medical or otherwise, was performed that supports discontinuance of the benefits.

The defendant's response to the plaintiff's motion for summary judgment is included in its motion for summary judgment and supplement. There, the defendant contends that the defendant gave the policy its legally correct interpretation, no substantial conflict of interest exists simply because the defendant serves as both the insurer and administrator of the Plan, and that substantial evidence supports the defendant's decision. Therefore, the defendant asserts, it did not abuse its discretion.

B.

In its letter terminating benefits dated December 22, 2000, the defendant recited the policy definition and its stated reason(s) for terminating the plaintiff's benefit. The relevant portion of the policy that was also recited in the defendant's letter provides:

> If the Covered Person is eligible for the 24 month Own Occupation Benefit, "Disability" or "Disabled" means during the Elimination Period and the next 24 months of Disability the Covered Person is unable to perform *all of the material and substantial duties of his occupation on an Active Employment basis* because of an Injury or Sickness; and [emphasis added].

> After 24 months of benefits have been paid, the Covered Person is unable to perform, with reasonable continuity, all of the material and substantial duties of his own or any other occupation for which he is or becomes reasonably fitted by training, education, experience, age, and physical and mental capacity.

The letter went on to state its basis for the termination of benefits as follows:

> While it is apparent you were ill and met the criteria for your policy's definition of disability initially, based on the medical information received, you no longer meet your Long Term Disability Policy's definition of disability. Therefore, we must close your claim for benefits, effective December 31, 2000.

III. UNDISPUTED FACTS

It is apparent from the plaintiff's and the defendant's papers that there is no dispute as to certain facts. First, the plaintiff never reached a point where the second part of the disability definition came into play. The plaintiff's benefits were discontinued during the first twelve (12) months. Additionally, the undisputed facts show that: (a) the plaintiff was determined eligible for the disability benefits; (b) the entirety of what is known about the plaintiff's medical condition is based upon the reports provided by the plaintiff's physicians; and (c) the definition or interpretation of the term "disability" is not disputed, What appears to be in dispute is

the defendant's interpretation of the medical evidence and its understanding of how to apply the definition of disability under the Plan. The Court will address each of these areas in turn.

A.

The plaintiff's eligibility for disability benefits is admitted by the defendant in its letter of termination. In its December 22 letter, the defendant stated that "it is apparent" that the plaintiff "met the criteria" for disability benefits under the policy. Thus, this issue requires no further comment and the Court moves to the second aspect of this discussion, the medical evidence.

B.

The determination of medical disability was based initially on Doctor Diana Hayes' diagnosis that the defendant was disabled. Dr. Hayes determined that the plaintiff suffered from fibromyalgia and that she was diabetic and insulin dependent. The plaintiff's condition was such that Dr. Hayes determined that the plaintiff suffered a Class 4 physical impairment and a Class 4 mental impairment. These impairments resulted in a finding that the plaintiff was functionally impaired and incapable of performing a full eight (8) hours per day work schedule. Moreover, due to stress and the plaintiff's need to perform substantial driving as a part of her job function, Dr. Hayes cautioned that the plaintiff was unable to perform all of the material and substantial duties of her occupation. That preliminary determination did not change in February.

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In February, Dr. Hayes reiterated her initial diagnosis. She noted also that the plaintiff was suffering from fatigue, weakness and trunk and limb pain. At that time, the plaintiff also complained that simple life functions such as putting on her shoes and socks caused pain. As a result, an EMG was performed in March, which results were consistent with a myopathic process. The plaintiff was diagnosed as suffering possibly from an inflammatory myopathy.

Later in April, Dr. Mavis Fujii, a neurologist examined the plaintiff. He reported impairment of muscles due to pain and, therefore, proposed a muscle biopsy for evaluation. He concluded that the plaintiff was suffering polymyositis, which was causing muscle impairment. Dr. Fujii determined that the plaintiff could not stand, walk, climb stairs, ladders or perform a job that required driving and that she should not lift more than 10 pounds over a substantial period of time. He too, concluded that the plaintiff could not work an eight (8) hour work day.

This conclusion was shared by Dr. Evans Matwijiw, an endocrinologist. Dr. Matwijiw advised the plaintiff that she should not stand more than two (2) hours per day. That she could not perform on the job driving, pushing, pulling, reaching, handling/grasping, and labor that requires five finger dexterity. He determined that the plaintiff was totally disabled.

Dr. Jovan Popovich, a rheumatologist found an elevated CPK, confirmed that the plaintiff's EKG was consistent with the myopathic process, and that she was suffering from fibromyalgia. When the plaintiff's CPK decreased,

Appendix B

Dr. Popovich sought to determine whether the plaintiff's functionability was increased. He found the contrary-it had worsened. This condition persisted. According to the plaintiff and Dr. Popovich's examination, the plaintiff's condition was consistent with the plaintiff's complaints. As late as August 2000, Dr. Popovich continued to see an elevated CPK, continued to document muscle pain and decreased CPK with worsening of the plaintiff's functional ability. An M1ZI to look for myositis was ordered. And, concerns about supraclavicular soft tissue swelling were the subject of a referral to a surgeon. In September, the MRI revealed enlarged lymph nodes and problems with one of the blood vessels. However, the pain in the muscles and soft tissue continued and inflammatory myopathy was not be ruled out.

On January 31, 2001, Dr. Popovich issued a letter reconfirming her earlier diagnosis of fibromyalgia. She described the plaintiff's condition as chronic, with widespread musculoskeletal pain and fatigue disorder. Dr. Popovich further explained that routine laboratory testing looks normal even though the plaintiffs condition persists.

Thus, the Court concludes that the plaintiff's medical history did not change significantly, if at all during the twelve (12) months that the plaintiff received disability benefits. The Court moves to the final area of dispute between the parties-the issue of whether the plaintiff's benefits were wrongfully terminated.

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C.

The final area of dispute between the parties concerns the application of the definition of the term "disability" by the defendant. Again, there is no dispute between the parties concerning the meaning of "disabled." However, the defendant's litigation manager in her deposition responded as follows:

> Q.: Under that definition [speaking of disability], if Ms. Ellis could not perform one of the material duties of her occupation, she would be disabled?
>
> A.: Yes.

Based on testimony, the defendant's view of the appropriate interpretation of the term "disability" is the same as that of the plaintiff. Therefore, this area does not raise a disputed fact or law issue for the fact finder. Thus, the Court holds that if the plaintiff could not perform any one of the material duties of her occupation, she was entitled to continue on disability benefit.

III. STANDARD OF REVIEW

A. *Summary Judgment Standard*

Summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R.

Civ. P. 56(c) (2003). The moving party bears the initial burden of "informing the Court of the basis of its motion" and identifying those portions of the record "which it believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). In adjudicating a motion for summary judgment, the Court must view all facts in the light most favorable to the nonmoving party. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (citing United States *v. Diebold, Inc.*, 369 U.S. 654, 655 (1962)).

Once the moving party meets its burden, the nonmoving party must "go beyond the pleadings" and set forth "specific facts" in the record "showing that there is a genuine issue for trial." *Celetex Corp.*, 477 U.S. at 324. An issue is "genuine" if the evidence is sufficient for a reasonable jury to return a verdict for the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-49 (1986). Failure on the part of the nonmoving party to offer proof concerning an essential element of its case necessarily renders all other facts immaterial and mandates a finding that no genuine issue of fact exists. *Saunders v. Michelin Tire Corp.*, 942 F.2d 299, 301 (5th Cir. 1991).

The primary inquiry here is whether the material facts present a sufficient disagreement as to require a trial, or whether the facts are sufficiently one-sided that one party should prevail as a matter of law. *Anderson,* 477 U.S. at 251-52. The substantive law of the case identifies which facts are material. *Id.* Only disputed facts potentially affecting the outcome of the suit under the substantive law preclude the entry of a summary judgment. *Id.*

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In an ERISA case where the insurer also serves as the administrator of an ERISA Plan, the insurer has a financial interest in the outcome of the claim determination. Therefore, a court should give less deference to the insurer's decision in view of this fact. *See Lain v. Unum Life Insurance Company ofAmerica,* 279 F.3d 337, 346 (5th Cir. 2002); *Vega v. National Life Insurance Services, Inc.*, 188 F.3d 287, 302 (5th Cir. 1999). The Court now turns to its analysis.

V. ANALYSIS

At the outset, the Court states its opinion that the defendants arbitrarily discontinued the plaintiff's disability benefits. A review of the medical records show that the plaintiffs medical condition did not change, appreciably between January 2000 to December 2000. Thus, it is apparent that the defendant places greater weight on its video investigation than on the scientific evidence or its own medical expert. The video revealed that the plaintiff would leave home from time-to-time to visit the doctor or shop for groceries. On one occasion the plaintiff was seen carrying what is described as several "large" grocery bags from her car into her home. However, there is no evidence as to what was contained in the bags or whether the weight of the contents exceeded 10 pounds. The medical evidence as well as the plaintiff's activities questionnaire confirm that the plaintiff can lift 10 pounds and more. In addition, the plaintiff admits that she can shop for groceries or do chores like watering her lawn, even though she tries to avoid them due to pain. However, the medical evidence establishes that these activities cannot be sustained over a period of time and with any degree of consistency. Thus, the video is no evidence

and is inadmissible as evidence as to whether the plaintiff can perform all of the material duties of her occupation.

The defendant also sought and secured an independent medical examination, conducted by Dr. Steven M. Croft on November 8, 2000. Dr. Croft confirmed the reports of doctors Lucci, Hayes, Fujii and Popovich. His impression was that the plaintiff suffered a condition, possibly fibromyalgia, although he too was unprepared to make a definite diagnosis. He was "doubtful" that the plaintiff was suffering polymyositis, but confirmed that he did not have sufficient data to rule it out. In fact, Dr. Croft conceded that the plaintiff may have a "very mild case" of polymyositis because that would explain the plaintiff's symptoms. He discounted the fact that the plaintiff complained of constant pain; not because any medical or scientific examination revealed this fact, but because he viewed the video. He concluded that based on his objective finding there is insufficient "evidence" to support the view that the plaintiff is unable to perform her duties in a sedentary job. However, this finding begs the issue because only a part of the plaintiff's duties could be done in a sedentary posture. He failed to speak to the forty (40) percent[1] of the plaintiff's occupation that is not sedentary in nature. Moreover, he seemed to be confused as to what his duties entailed. It was not Dr. Croft's duty to determine whether the plaintiff could work at all. It was to determine whether she could do all of the critical functions of her

---

1. The defendant admits that only 60% of the plaintiff's occupation function is sedentary. The remainder requires, lifting, standing, reaching walking and driving. In fact, 20% of the plaintiff's occupation requires driving under stressful circumstances.

occupation. For the plaintiff, this would include functions other than sitting, and would require a full day's work.

The record shows that no tests were done by Dr. Croft that resulted in "objective" findings contrary to those found by the other physicians. Beyond the physical examination and review of the plaintiff's treating physicians, no separate tests were reported. Interestingly, Dr. Croft states that when he palpated the plaintiff's shoulder and thigh muscles, the plaintiff almost became tearful and complained of pain. Finally, Dr. Croft admitted that a repeat EMG and an evaluation by an independent rheumatologist would be appropriate.

The Court is of the view that Dr. Croft's use of terms "doubtful" and "possible" and his confusion as to the disability standard at issue renders Dr. Croft's medical determination immaterial. Thus, his examination was based on insufficient medical evidence to reach a conclusion different than that reached by the plaintiffs treating physicians. In fact, Dr. Croft does not conclude that the plaintiff can perform all the material duties of her occupation. Instead, he simply concludes that she can work in a sedentary occupation. This conclusion misses the mark.

Thus, the Court concludes and holds that the independent report of Dr. Croft fails to create a disputed fact issue for the fact finder. Equally important, the report fails to refute the medical findings upon which the defendant first made its determination that the plaintiff was eligible for disability benefits.

The Court, therefore, FINDS and HOLDS that there is no credible, substantial or positive evidence that demonstrates that the plaintiff, once eligible, became ineligible for disability benefits. Further, there is no evidence to support the conclusion that the plaintiff can perform all of the material duties of her occupation as a mortgage loan officer. Finally, the independent medical examination does not address the issues of disability, as defined by the policy. Therefore, the defendant abused its discretion in applying a disability standard different than the standard established in the policy and summary judgment is appropriate for the plaintiff.

It is Ordered that the defendant provide a full accounting of benefits owed the plaintiff from January 1, 2001, to the date of this Memorandum and Order to the Court within ten (10) days of entry of this Order. Also, the defendant's counsel shall file, if appropriate, a cross-affidavit concerning the reasonableness of the plaintiffs counsel's attorney's fee within ten (10) days of the entry of this Order. [*See* attachment 57 to the plaintiffs supplement to its motion for summary judgment, Inst. No. 22].

Signed this 2nd day of June, 2003.

s/ Kenneth M. Hoyt

KENNETH M. HOYT
United States District Court Judge

APPENDIX C — SUPPLEMENT TO MEMORANDUM OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS, HOUSTON DIVISION DATED JULY 31, 2003

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CIVIL ACTION NO. H-01-3963

LINDA ELLIS,

Plaintiff,

vs.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

Defendant.

SUPPLEMENT TO MEMORANDUM OPINION AND ORDER

The Court finds it appropriate to supplement its Memorandum Opinion and Order entered on June 3, 2003. The necessity to supplement is based on the Court's implied finding that the defendant intentionally violated the law in denying disability benefits to the plaintiff. [*See* Memorandum Opinion and Order, p. 6(c)], and did so in bad faith.

The record reveals that the defendant's litigation manager was aware and agreed that the plaintiff qualified for disability benefits. Yet, the defendant set out to prove that the plaintiff

was capable of engaging in certain activities. This diversion by the defendant was intentional and calculated to harm the plaintiff. Even after the plaintiff qualified for disability according to Social Security standards, the defendant would not yield. Moreover, the defendant has had many opportunities to reexamine the plaintiff and its position and has failed to do so. Therefore, the Court is of the opinion that the plaintiff is entitled to an award of attorney's fees, prejudgment interest. *See* 29 U.S.C. § 1132(g)(1); *see also Hansen v. Continental Ins. Co.*, 940 F.2d 971, 984 (5th Cir. 1991).

The Court is also of the opinion that the defendant's bad faith and ability to pay an attorney's fee are not an issue. An award of attorney's fees would serve the ends of justice and deter other similar conduct. *See Salley v. E. I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1017 (5th Cir. 1992).

It is, therefore, the opinion of the Court that the additional relief requested by the plaintiff should be granted.

It is so ORDERED.

Signed this 31st day of July, 2003.

s/ Kenneth M. Hoyt
KENNETH M. HOYT
United States District Court Judge

APPENDIX D — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT DENYING PETITION FOR REHEARING FILED JANUARY 14, 2005

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 03-20623

LINDA ELLIS

Plaintiff - Appellee-Cross-Appellant

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

Defendant - Appellant-Cross-Appellee

Appeal from the United States District Court for the Southern District of Texas, Houston

ON PETITION FOR REHEARINGAND REHEARING EN BANC

(Opinion 11/19/04, 5 Cir., ____, ____ F.3d ____)

Before JOLLY, WIENER and BARKSDALE, Circuit Judges.*

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* Judge Pickering was a member of the original panel but retired from the Court on 12/8/04 and, therefore did not participate in this decision.

Appendix D

PER CURIAM:

The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

ENTERED FOR THE COURT:

/s/ Jacques L Wiener, Jr
United States Circuit Judge

(2)

Supreme Court, U.S.
FILED
MAY 18 2005
OFFICE OF THE CLERK

No. 04-1395

IN THE

Supreme Court of the United States

LINDA ELLIS,

Petitioner,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether, based on the substantial evidence contained in the administrative record, Liberty Life Assurance Company of Boston ("Liberty" or the "Company") abused its discretion in terminating Linda Ellis' ("Ellis") ERISA-covered disability benefits.

RULE 29.6 STATEMENT

Liberty Life Assurance Company of Boston states that it has the following parent corporations:

Liberty Mutual Holding Company Inc.
LMHC Massachusetts Holdings Inc.
Liberty Mutual Group Inc.
Liberty Mutual Insurance Company
Liberty Mutual Fire Insurance Company

Liberty Mutual Holding Company Inc. owns 100% of the stock of LMHC Massachusetts Holdings Inc. which owns 100% of the stock of Liberty Mutual Group Inc. Liberty Mutual Group Inc. owns 100% of the stock of Liberty Mutual Insurance Company and 100% of the stock of Liberty Mutual Fire Insurance Company. Liberty Mutual Insurance Company owns 90% of the stock and Liberty Mutual Fire Insurance Company owns 10% of the stock of Liberty Life Assurance Company of Boston. No publicly held company owns 10% or more of the stock of Liberty Life Assurance Company of Boston.

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STATUTES INVOLVED

Ellis' list of involved statutes is over-inclusive. Sections 1132(a)(1)(A), 1132(a)(2), and 1132(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA") are not at issue in this case. Rather, the only section of ERISA relevant to the disposition of this matter is 29 U.S.C. § 1132(a)(1)(B) which provides:

> **(a) Persons empowered to bring a civil action**
>
> A civil action may be brought —
>
> **(1)** by a participant or beneficiary —
>
> . . .
>
> **(b)** to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. . . .

(emphasis in original) 29 U.S.C. § 1132(a)(1)(B).

STATEMENT OF THE CASE

This case presents nothing more than a run-of-the-mill insurance benefits dispute that neither the panel nor Fifth Circuit *en banc* deemed worthy of reconsideration. Indeed, as of the filing of this response, no Circuit Court of Appeals has cited this case and, of the district courts referencing this matter, not one has indicated disagreement with the holding or analysis of the Fifth Circuit.

In November 1999, Ellis, a former Chase Manhattan Bank ("Chase" or the "Bank") loan officer, went on medical

leave from the Bank, contending that she was totally disabled from working at the Bank (or anywhere else) in any capacity. The loan officer job that Ellis used to perform involves the processing of loan applications for Chase customers and is purely sedentary in nature.

Liberty is a nationwide insurance carrier. The Company issued a group long term disability insurance policy (the "Policy") to the Bank in January 1997. The Policy, which forms part of Chase's employee welfare benefits plan under ERISA, provides long term disability benefits to eligible Bank employees. As the Policy's insurer, Liberty possesses the sole authority to make all coverage, eligibility, and interpretation decisions concerning the Policy.

Under the terms of the Policy, a Chase employee may be eligible for "total," "partial" (also known as a "work incentive benefits"), or no disability benefits at all. Total disability benefits are payable for the first 24 months of disability to an employee who is "unable to perform all of the material and substantial duties of [her] occupation on an Active Employment basis because of an Injury or Sickness" and after 24 months, benefits are payable if the employee "is unable to perform with reasonable continuity, all of the material and substantial duties of [her] own or any other occupation for which [she] is or becomes reasonably filled by training, education, experience, age and physical and mental capacity."

In turn, work incentive benefits may be available to an eligible Bank employee or ex-employee who is "partially disabled," meaning "able to perform one or more, but not all, of the material and substantial duties of [her] occupation *on an Active Employment or part-time basis*; or . . . able to perform all of the material and substantial duties of [her] own or any other occupation *on a part-time basis*." As the terms "Active employment," "part-time basis," and "work

incentive" imply, such benefits are only available to persons who are, in fact, employed in some capacity during the relevant time frame.[1] Ellis, however, at least during the administrative process, never asserted that she was partially disabled and, therefore, entitled to work incentive benefits. Rather, she argued that she was unable to work anywhere in any capacity. Consistent with her representations, Liberty determined that Ellis was, in fact, unemployed between the time she applied for benefits and the final disposition of her claim. Consequently, the partial disability, or "work incentive," provisions of the Policy do not apply to Ellis.

Nevertheless, between December 1999 and May 2000, Ellis did receive some compensation. For instance, she qualified for group short term disability benefits under a different Chase insurance policy issued by Liberty — *Ellis' receipt of short term disability benefits under a different policy of insurance are not at issue here.* When Ellis' short term insurance coverage terminated and the Bank's group long term disability Policy became applicable to Ellis, Liberty began an investigation into Ellis' possible qualification for long term disability benefits. While the Company was investigating Ellis' long term disability claim, it also paid her long term disability benefits. By paying Ellis long term

---

1. *Cook v. Liberty Life Assurance Co. of Boston*, 320 F.3d 11, 22 (1st Cir. 2003) does not support Ellis' argument that the definitions of total and partial disability are not mutually exclusive. (Pet. at 18 n.2). In truth, *Cook* stands for the proposition that, while total disability benefits are available to persons who cannot work at all, partial disability benefits are to be paid *only* when an individual is actively (albeit on a limited basis) working. *Cook*, 320 F.3d at 22 n.11. The court summarized the relevant policy provision as follows: "someone who is partially disabled and thus *unable to work full-time* can receive a 'Loss of Earnings Monthly Benefit' to make up for some of the gap between her *former salary* and her *part-time salary.*" Such an individual, however, must not earn "more than 20% of her former salary. . . ." (emphasis added). *Id.* at 22.

disability benefits during the investigatory period, the Company ensured (whatever the final outcome of the inquiry) that Ellis would not go without compensation between the time her short term benefits ran out and Liberty completed its probe (which, in this case, lasted for more than six months).

Had Liberty not paid long term disability benefits to Ellis during the investigatory period, Ellis would have had no means to support herself during the six month investigatory period even if Liberty ultimately determined that she was totally disabled within the meaning of the Policy — a waiting period likely to be harmful to legitimate claimants for disability benefits. Erring on the side of caution (by paying Ellis benefits during the course of the Company's investigation), Liberty, of course, ran the risk of never recouping monies it overpaid Ellis if Ellis was not, in fact, disabled within the meaning of the Policy. In the end, this is exactly what happened.

Specifically, based on the evidence contained in Ellis' short term disability file, as well as new (and substantial) evidence the Company gathered from sources such as Ellis' physicians, her lawyer, an independent medical examiner, Liberty's nursing staff, and private investigators, Liberty terminated its inquiry on December 22, 2000 concluding that Ellis was not totally disabled within the meaning of the Policy. Ellis appealed Liberty's decision in January 2001, and she and her attorney submitted additional evidence to the Company. Liberty considered this information, but determined that it would not change the outcome of Ellis' case; therefore, Liberty upheld its claim denial in March 2001. *Liberty did not seek to recover its overpayment of long term disability benefits made to Ellis between May and December 2000.*

Based upon its belief that Ellis' initial qualification for short term disability benefits (under a different policy of insurance) and Liberty's decision to pay long term disability benefits while the Company investigated the long term disability claim estopped Liberty from denying that Ellis was totally disabled, the district court granted, in part, summary judgment in favor of Ellis and denied, in part, summary judgment in favor of Liberty. The Court of Appeals for the Fifth Circuit reversed and rendered judgment in favor of Liberty (and affirmed that part of the judgment already favorable to Liberty), holding simply that the Company did not abuse its discretion in denying the long term disability claim and terminating benefits. Consistent with this Court's, other Circuit Courts of Appeal, and Fifth Circuit precedents, the panel re-stated the oft-cited proposition that a district court must affirm the decision of a plan fiduciary when substantial evidence supports a decision to deny or terminate ERISA-covered benefits.

REASONS FOR DENYING THE PETITION

I. Review is not Appropriate Because the Result Reached by the Court of Appeals for the Fifth Circuit was in Full Accord With Supreme Court Authority.

To support her claim that the panel decision is in conflict with Supreme Court precedent, Ellis implies that the lower court erred because it did not "credit [her] reliable evidence of disability, including the opinions of the insured's treating physicians;" failed to "discuss[]" (to her liking) "the considerable medical evidence provided by Ellis' treating physicians or the factual information Ellis provided;" did not give "considerable weight" to a Social Security Disability Insurance ("SSDI") claim determination; and allowed an affidavit to "trump" deposition testimony. (Pet. at 16, 21, 27). She also chastises the panel for failing to make more than a "vague reference" to each piece of evidence contained in the administrative record. (Pet. at 27).

These evidence-based disagreements with the Court of Appeals amount to nothing more than a request for the Supreme Court to correct perceived errors in: (i) fact (*e.g.*, whether Ellis' treating physicians' records were contradictory, whether the objective tests demonstrated that Ellis had some work capacity, whether the independent medical examiner's assessment was correct, and whether Liberty should have relied upon videotaped surveillance and private investigation reports); and (ii) application of the law, as stated in *The Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 123 S. Ct. 1965 (2003) and *Cleveland v. Policy Mgt. Sys. Corp.*, 526 U.S. 795, 119 S. Ct. 1597 (1999), to the specific facts of her case (*e.g.*, "what weight should the court have given the treating physicians' records, SSA determination, affidavit, and deposition testimony?"). This Court has cautioned that such issues "rarely" rise to the level of compelling reasons to grant *certiorari*. SUP. CT. R. 10. Indeed, over the past five years, the Court has denied *certiorari* in at least 15 disability plan cases which raised similar issues.[2]

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2. *See UNUM Life Ins. Co. v. Fought*, No. 04-1000, 2005 WL 218389 (May 2, 2005); *Nord v. The Black & Decker Disability Plan*, __ U.S. __, 125 S. Ct. 62 (2004); *Harrell v. CNA Ins. Co.*, __ U.S. __, 125 S. Ct. 43 (2004); *Reliance Standard Life Ins. Co. v. Lasser*, __ U.S. __, 124 S. Ct. 2390 (2004); *Wagner v. First Unum Life Ins. Co.*, __ U.S. __, 125 S. Ct. 416 (2004); *Maniatty v. UNUM Provident Corp.*, 540 U.S. 966, 124 S. Ct. 431 (2003); *Farfalla v. Mutual of Omaha Ins. Co.*, 540 U.S. 875, 124 S. Ct. 222 (2003); *Fallo v. Piccadilly Cafeterias, Inc.*, 537 U.S. 1002, 123 S. Ct. 487 (2002); *Marx v. Meridian Bancorp, Inc.*, 537 U.S. 885, 123 S. Ct. 128 (2002); *Marshall v. Delta Family-Care Disability and Survivorship Plan*, 534 U.S. 1162, 122 S. Ct. 1173 (2002); *Cochran v. Trans-General Life Ins.* Co., 534 U.S. 887, 122 S. Ct. 198 (2001); *Razvi v. Guarantee Life Ins. Co.*, 534 U.S. 1041, 122 S. Ct. 617 (2001); *Perez v. Aetna Life Ins. Co.*, 531 U.S. 814, 121 S. Ct. 49 (2000); *Conley v. Pitney Bowes, Inc.*, 528 U.S. 1136, 120 S. Ct. 979 (2000). By contrast, since

(Cont'd)

Moreover, even if the issues Ellis raises could be said to be of some national import, the Fifth Circuit's opinion is consistent in every respect with *Nord* and *Cleveland*. First, those cases stand for the proposition that regulations and caselaw developed under the Social Security Act ("SSA") are not generally applicable to other types of disability cases such as those arising under ERISA or the Americans with Disabilities Act ("ADA"). *See e.g.*, *Nord*, 538 U.S. at 832-35, 123 S. Ct. at 1971-72 ("of prime importance" is to recognize that "critical differences" exist between SSA and ERISA); *Cleveland*, 526 U.S. at 803-05, 119 S. Ct. at 1602-03 (comparing and contrasting SSA with ADA). Thus, in *Nord*, this Court rejected the importation of the SSA's "treating physician rule" into ERISA cases, and in *Cleveland*, this Court held that the SSA and ADA are just dissimilar enough that an ADA plaintiff should be allowed to "explain" why differences existing between assertions she made in an ADA lawsuit and those made in an SSA proceeding are inconsequential. *Nord*, 538 U.S. at 832-34, 123 S. Ct. at 1971-72. *Cleveland*, 526 U.S. at 805-06, 119 S. Ct. 1603-04.

(Cont'd)

the passage of ERISA, this Court has granted *certiorari* in only 5 disability plan cases. *See Nord*, 538 U.S. 822, 123 S. Ct. 196; *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358, 119 S. Ct. 1380 (1999); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549 (1987); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S. Ct. 3085 (1985). In each of the cases in which this Court granted a petition for *writ of certiorari*, some issue of national significance, with which the lower courts struggled, surfaced — such as whether to adopt the SSA's "treating physician rule" in ERISA cases (*Nord*), the scope of ERISA's preemption and savings clauses (*Ward, Taylor, Dedeaux*), and whether an ERISA fiduciary could be held personally liable for compensatory or punitive damages (*Russell*). Even a case once deemed "certworthy" lost its luster because the petitioner, like Ellis here, sought a second review solely to correct perceived errors in the lower court's judgment. *See Nord*, __ U.S. __, 125 S. Ct. 62.

Therefore, to the extent the Fifth Circuit rejected the notion that Ellis' treating physicians' opinions were not entitled to greater weight than an independent doctor's findings, the court correctly applied the law. The court also properly followed Supreme Court precedent to the extent that it decided the SSA disability determination — which relied on statutory language substantially different from the Policy's language, was subject to detailed regulations and regulatory presumptions not found in ERISA, and was rendered based on evidence other than that contained in the ERISA administrative record — was not dispositive of Ellis' ERISA claim.

Second, with respect to the question of what weight should be given a post-deposition affidavit, this Court, in *Cleveland*, recognized that the lower federal courts "have held with virtual unanimity" that, though a party cannot "simply" contradict a deposition with a subsequent affidavit, she nonetheless, has the right to "explain[]" apparently disparate statements. *Id.* As a result, Ellis' admission that Liberty's litigation manager sufficiently accounted for her so-called inconsistent statements militates against Supreme Court review of this matter. (*See* Pet. at 16) ("in a post-deposition Affidavit, McGee *explained* that she was confused by this [deposition] question. . . ."). Consistent with this admission, the Fifth Circuit described in considerable detail the reasons the witness' explanation was worthy of credence. *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262, 271 (5th Cir. 2004) (deposition question confused witness, Company consistently interpreted total disability provisions of Policy, and other witnesses corroborated affidavit testimony).

Finally, Ellis has not cited, and Respondent has not found, any authority for the proposition that an appellate court errs by failing to identify, and describe the relevance of, each

piece of evidence in the administrative record when rendering a decision in an ERISA case. Such a rule is unsound because it would waste precious judicial resources while adding little, if anything, of value to the parties' or general public's understanding of the legal issues involved.

In any event, if Ellis' concern is with the veracity of the appellate court, the Fifth Circuit noted numerous times in its opinion that "substantial evidence" existed in the lengthy administrative record to support Liberty's decision. *Ellis*, 394 F.3d at 267, 271, 274 & nn.23, 27. These notations, combined with various procedural safeguards (*i.e.*, the Fifth Circuit only decided this matter after reading the parties' briefs, reviewing the record on appeal, hearing oral arguments, and correcting its initial opinion), are sufficient indicators that the panel took its job seriously, considered all of the information the parties submitted, and crafted a well-reasoned opinion.

II. Review is not Appropriate Because no Circuit Split Exists on the Questions Ellis Presents.

With respect to the lower federal courts, Ellis does not identify a true "split" in the circuits. Instead, she parses unique facts from wildly different lawsuits to advocate that a national "uniformity" standard govern the interpretation of all ERISA disability plans. (Pet. at 16) (urging this Court to adopt a rule that would "promote uniformity of construction of disability insurance policies"). Ellis' argument is both illogical (given that the abuse of discretion standard *presumes* different fiduciaries will interpret different language in different plans differently, the circuit courts can *never* split over this issue) and against public policy (to the extent "[u]niformity" is truly "vital to the purposes of ERISA," it is Congress' province to dictate what benefits, if

any, employers shall provide under ERISA).[3] *See Nord*, 538 U.S. at 833, 123 S. Ct. at 1971 (quoting *Lockheed Corp. v. Spink*, 517 U.S. 882, 887, 116 S. Ct. 1783, 1788 (1996)) (Congress has not seen fit to require employers to provide any specific type or level of ERISA benefits); *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358, 119 S. Ct. 1380 (1999) (discussing Congressional action/inaction with respect to regulation of insurance companies); *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 113-17, 109 S. Ct. 948, 956-57 (1989) (if plan confers "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," courts review decisions for an abuse of discretion).

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3. Moreover, Congress *has* expressed its will by declaring, for instance "the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. § 1011. Congress has also stated that "any State law which regulates insurance" shall not be subject to ERISA preemption. 29 U.S.C. § 1144(b)(2)(A). Thus, unless Congress intervenes, it is the States to whom the right to determine whether "uniform" standards of insurance contract interpretation are desirable, is reserved, providing yet another reason that this Court should avoid taking action upon Ellis' request. In any case, Ellis' argument is taken (out of context) from an unbroken line of Fifth Circuit cases dating to 1979 that stand for the proposition that the "uniformity" test applies to a plan administrator's interpretation of a particular plan's provisions over time, but not to other plan administrators' interpretations of other plans (even when those other plans contain the same or similar language). *See, e.g., Ellis*, 394 F.3d at 270 (three factors, including "whether the administrator has given the plan a uniform construction" are relevant in determining whether interpretation was legally correct); *Bayles v. Central States, Southeast & Southwest Areas Pension Fund*, 602 F.2d 97, 99-100 & n.3 (5th Cir. 1979) (first applying uniformity test). *See also Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109, 109 S. Ct. 948, 953 (1989) (citing *Bayles* for use of arbitrary and capricious standard in older ERISA cases).

As a result, courts should not apply some "cookie-cutter" interpretation of "disability" to every ERISA-governed insurance policy issued by every insurance company to every type of employer in every part of the Country. Supporting Liberty's view, even a cursory examination of Ellis' authorities reveals that each case is either unique and fact-specific, or is in *agreement* with *Ellis*. For example, the Tenth Circuit decided *Caldwell v. Life Ins. Co. of North America*, not based on issues of plan interpretation, but because the administrator made erroneous *factual* determinations. *Caldwell v. Life Ins. Co. of North America*, 287 F.3d 1276, 1283-86 (10th Cir. 2002) ("administrator admitted that she based her decision in part on the determination of the workers' compensation judge . . . despite not knowing 'what the standard was in Kansas'" to qualify for workers' compensation benefits, "administrator also ignored evidence," administrator "based her decision on a skewed reading of Mr. Caldwell's medical records," and "administrator also misconstrued Mr. Caldwell's testimony. . . .").

Kinstler v. First Reliance Standard Life Ins. Co., dealt with, among other issues, "the appropriate standard of review . . . when an ERISA claim is denied because of an adverse determination . . . with respect to a *factual* question." (emphasis added) *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 245 (2nd Cir. 1999). Specifically, the administrator depended upon an incorrect description of Kinstler's job duties. *Id.* at 248. Also, in contrast to this case in which the parties agree that the abuse of discretion standard applies, "the *de novo* standard of review applie[d]" in *Kinstler* because the insurance policy granted no "clear reservation of discretion to the plan administrator." *Id.* at 245.

Another reason *Kinstler* is inapplicable is because the language in that insurance policy was vastly different from that which appears in the Policy under consideration today:

> "Totally Disabled" and "Total Disability" mean that as a result of an Injury or Sickness . . . an Insured

> cannot perform the material duties of his/her regular occupation. We consider the Insured "Totally Disabled" if due to an Injury or Sickness he or she is capable of only performing the material duties on a part-time basis or part of the material duties on a Full-time basis . . . .

Id. Finally, Ellis is simply incorrect when she says the *Kinstler* court conducted a wholesale review of the definition of disability. In actuality, the Second Circuit contemplated only what meaning to give the words "regular occupation" and "material duties" — terms that were not considered by the Fifth Circuit in *Ellis*. *Id.* at 248-49.

Not only is *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan* distinguishable on its facts, its analysis is actually *consistent* with *Ellis*. While the plan administrator in *Saffle* did abuse its discretion by arbitrarily adding a "reasonable accommodation" requirement that did not exist in, and was contrary to, the plain language of the plan, the *reason* that interpretation was legally incorrect was because it defined plan terms in a way that "effectively convert[ed] benefits for total disability into benefits for partial disability" — the exact same problem that exists with the "uniform standard" Ellis now proposes for all insurance policies. *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 456-59 (9th Cir. 1996). Notably, Ellis glosses over the *Saffle* court's most relevant holding:

> we cannot say that the Committee lacks discretion to construe 'each and every duty of [the participant's] regular occupation' to mean *all of the substantial and material duties of her regular occupation*. To the extent this is what the Committee meant, its construction is consistent with the plain language of the Plan because it

> assumes that the participant is "completely unable to perform each and every duty" that matters.

Id. at 459 (emphasis added).

Next, Ellis relies on *McClure v. Life Ins. Co. of North America*, 84 F.3d 1129 (9th Cir. 1996). That *per curiam* opinion is distinguishable because: (i) the insurance policy did not provide discretionary authority to the administrator and, as a result, the court reviewed the decision *de novo*; (ii) the administrator stipulated that McClure "was *unable to perform all of the physical tasks required of him . . .*;" and (iii) the insurance policy used a different definition of disability. (emphasis in original) *McClure*, 84 F.3d at 1133-34. In contrast to Ellis' assertions, the Ninth Circuit never held that an "each and every" definition of disability was improper. Rather, on the facts presented (the insurance policy apparently did not provide partial disability benefits for a person who could perform some, but not all, of his job duties), the lone phrase "inability .. . to perform every duty" was ambiguous. *Id.* at 1134. Such ambiguity, however, cannot be found in a policy, such as the one Liberty issued to Chase, that provides both total and partial disability benefits. *See Ellis*, 394 F.3d 271-72. *Accord id.* at 278 (conceding "to construe the policy differently than the administrator would create an internal inconsistency between the policy provisions for total disability and partial disability) (Pickering, J. dissenting).

Turning to *Hammond v. Fidelity & Guar. Life Ins. Co.*, 965 F.2d 428 (7th Cir. 1992), other than using a *de novo* review standard, that case, like *Saffle*, is in harmony with the Fifth Circuit's decision. Instead of discrediting any language from the insurance policy, the court relied on *Torix v. Ball Corp.*, 862 F.2d 1428 (10th Cir. 1988) to find that, with respect to "'general' disability provision[s]" (those

which provide benefits for persons unable to work in any occupation), "the insured should be entitled to recover provided he or she is unable to perform *all* of the substantial and material acts necessary to the prosecution of some gainful business or occupation." (emphasis added) *Hammond*, 965 F.2d at 430-31. Because Hammond's husband was capable of performing all of the material and substantial duties of a job, Hammond was not entitled to disability benefits and summary judgment in favor of the insurer was proper. *Id.*

What Ellis fails to mention about *Hammond* is that the Seventh Circuit made a distinction between general disability provisions and "occupational disability" provisions like the one considered by the Fifth Circuit in *Ellis*. *Id.* The two types of clauses are "substantial[ly]" different because occupational disability provisions "provide[] benefits if the claimant is unable to perform *his regular job*. . . ." (emphasis added) *Id.* *Accord Ellis*, 394 F.3d at 270 ("the LTD Policy provides that benefits are initially payable only to an employee who is 'unable to perform *all* of the material and substantial *duties of his occupation*. . . .'") (emphasis added). Given this distinction, even if the Seventh Circuit had expressed displeasure that general disability clauses require claimants to prove an inability to perform "each and every" duty of some occupation (which the court did not do), its holding would have been limited to general disability clauses and policies, not an occupational clause such as the one at issue in *Ellis*.

Ellis also cites *Torix* in support of her "conflict" argument, but that case too, as the court recognized, turned on "a question of fact that depends upon all the circumstances of [the] case." *Torix*, 862 F.2d at 1430 (quoting *Helms v. Monsanto Co.*, 728 F.2d 1416, 1420 (11th Cir. 1984)). Specifically, the general (as opposed to occupational) disability plan at issue in *Torix* provided benefits to workers

who were "prevented from engaging in any occupation," but apparently did not provide benefits for partial disability. Like *Hammond*, the issue of whether using an "each and every" standard under an occupational disability plan was proper, simply never came up. Instead, the court borrowed from insurance and social security cases, the concept of "gainful activity or employment." *Id.*, 862 F.2d at 1431. Thus, if Torix could "establish a physical inability to follow any occupation from which he c[ould] earn a *reasonably substantial income* rising to the dignity of . . . [a] livelihood," then he was disabled and, therefore, entitled to benefits. (emphasis added) *Id.* Here, of course, Ellis' situation is demonstrably different — she still has the ability to perform most of the material and substantial duties of her own job; therefore, unlike Torix, she also has the ability to earn a "substantial income" as a loan officer at a bank. *Ellis*, 394 F.3d at 270-74.

Finally, *Helms* does not help Ellis' quest for *certiorari*. *Helms*, of course, also turned on "a question of fact. . . ." *Helms*, 728 F.2d at 1420. Setting aside that the Monsanto plan too was a general, not occupational, disability insurance policy, the physician before whom the parties agreed to arbitrate their dispute testified that he believed Helms was not entitled to benefits unless he "had no 'conscious life.'" *Id.* at 1419-20. Such a standard was obviously contrary to the plain language of the plan which stated that benefits were due in the event a worker was "prevented . . . from engaging in any occupation for remuneration or profit. . . ." *Id.* ("such a standard would render the entire Monsanto [plan] totally meaningless.").

The court also made clear that, because this was a general disability policy review, the inquiry would focus on the meaning of "remuneration or profit," an issue not present when, as here, a court considers an occupational disability

provision. *Id.* (people almost always retain some "ability to earn a nominal sum unless . . . rendered completely immobile and without cognitive ability."). Interestingly, the Eleventh Circuit recognized that, in state insurance cases, disability is usually defined to mean (similar to the Chase Policy here) "unable to perform *all the substantial and material* acts of some gainful business or occupation." (emphasis added) *Id.* at 1420-21. *Helms*, therefore, is also consistent with *Ellis*.

In the end, Ellis' attempts to manufacture conflict where none exists must fail. Faced with the same set of circumstances, the courts to which Ellis refers in her petition, given their reasoning and analyses, would likely reach the same result as the Fifth Circuit. Accordingly, Supreme Court review is not warranted.

III. Review is not Appropriate Because the Panel's Decision is in Full Accord With Fifth Circuit Precedents.

Next, Ellis contends that the decision in this case conflicts with prior Fifth Circuit precedent. Not so: neither the panel nor *en banc* court perceived any so-called conflict. Consequently, they denied Ellis rehearing. Nevertheless, to bolster her conflict argument, Ellis cites *Lain v. UNUM Life Ins. Co.*, 279 F.3d 337 (5th Cir. 2002), a case that is so factually distinct from this matter as to be valueless.

In particular, *Lain* never discussed the propriety of an "each and every" standard as Ellis implies. The case also involved a different standard of review (*de novo*), insurance company (UNUM Life Insurance Company), employer (Schlanger, Mills, Macer & Grossberg), and ERISA plan than those considered by the *Ellis* court. *Lain*, 279 F.3d at 342.

Most importantly, the Schlanger Mills plan contained substantially different language than that found in the Chase

Policy, defining disability as meaning a person "cannot perform *each* of the material duties of [her] regular occupation. . . ." (emphasis in original) *Id.* Construing this precise phrase, the Fifth Circuit noted it was dissimilar to language found in a policy like Chase's. *Id.* at 344-45. According to the court:

> a senior benefit analyst at UNUM, testified that he interpreted the first-prong of the definition of "disability" as requiring Lain to be unable to perform *all* of her material duties before she would be considered disabled. *This is contrary to the plain language of the Policy* and to UNUM's interpretation of the same definition in other cases.

(emphasis added) *Id.* at 345. The contention, therefore, that *Ellis* and *Lain* are in conflict is simply false — the court found that the language of the two policies is nothing alike. *Id.*

Nor does the Court of Appeals' decision conflict with *Vercher v. Alexander & Alexander, Inc.*, 379 F.3d 222 (5th Cir. 2004). As with *Lain*, *Vercher* involved a different insurance company (Metropolitan Life Insurance Company)[4], employer (Alexander & Alexander, Inc.), ERISA plan, and plan language (disability means "completely unable to perform any and every duty of your occupation").[5] *Vercher*, 379 F.3d at 231. While the *Vercher* language could be said to be ambiguous, the court declined the opportunity to consider

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4. Adding to the dissimilarities, MetLife acted as a third party administrator, *not* an insurer in the *Vercher* case. *Vercher*, 379 F.3d at 231.

5. The Fifth Circuit found significant that Alexander & Alexander's ERISA plan did not provide for partial disability benefits. *Compare Vercher* 379 F.3d at 229 & n.9 *with Ellis*, 394 F.3d at 271-72 & n.23.

any interpretation issues. *Id.* ("we need not determine whether the interpretation . . . was an abuse of discretion"). It did not have to: irrespective of whether the phrase "completely unable to perform any and every duty" meant Vercher was *not* disabled if she *could* perform any trivial job or that she *was* disabled if she could *not* perform any trivial job:

> MetLife essentially determined that, if there were something she was unable (despite reasonable accommodation) to do that was indispensable or essential to the proper performance of her regular occupation, she would have received benefits. However, so long as she was able to perform all the substantial and important aspects of her job, with reasonable accommodation, and any aspects of the job that she could not perform with reasonable accommodation were, singularly or together, *not* indispensable or essential to the job, then she was not disabled.

(emphasis in original). *Id.*

For that reason, the Fifth Circuit held that "either under a *de novo* or an abuse of discretion standard, the defendants applied a legally correct definition of disability" based on that particular plan's language. *Id.* As a result, the background discussion of the law in another circuit, which provided context, but was not the holding of the case, was mere *dicta* and is not controlling. *See, e.g., Jama v. Immigrations & Customs Enforcement*, __ U.S. __, 125 S. Ct. 694, 706 n.12 (2005) ("[d]ictum settles nothing, even in the court that utters it."); *McDaniel v. Sanchez*, 452 U.S. 130, 101 S. Ct. 2224 (1981) ("dictum unnecessary to the decision in that case . . . is . . . not controlling in this case. . . .").

Further, contrary to Ellis' assertions, the court did not so much as hint that a "completely unable to work" standard is *per se* inappropriate.[6] Rather, the Fifth Circuit concluded that the district court erred in using a "completely unable to work" criterion solely because "it does not appear that the district court's definition . . . was the one that Alexander and MetLife actually applied . . . ." *Id.* at 230.

Next, Ellis says that, according to the dissent, the Policy was ambiguous. (Pet. at 19). A careful reading of the opinion, however, reveals that the dissent was in *agreement* with the majority on this issue. Although the dissent admitted that it would like to interpret the Policy another way, it ultimately concluded that Liberty's interpretation was "reasonable" and any other interpretation "would create an internal inconsistency" in the Policy rendering it meaningless. *Compare Ellis*, 394 F.3d at 278 (any interpretation other than Liberty's would create "an internal inconsistency") (Pickering, J., dissenting) *with Ellis*, 394 F.3d at 271-72 & n.23 ("Ellis's proffered interpretation . . . cannot be squared with the Policy's language" and would render Policy provisions "meaningless surplusage . . . .").

IV. Review Is Not Appropriate Because no Other Court is Likely to Reach a Different Result Based on the Unique Facts of This Case.

Finally, this Court should not issue a *writ of certiorari* to the Fifth Circuit because the lower court's decision, under the unique facts of this case, was right. Specifically, Chase's Policy, which provides for the payment of total disability payments to an individual who is "unable to perform the

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6. Even if it had, that interpretation is not consistent with Liberty's interpretation of the Chase Policy. *Ellis*, 394 F.3d at 270-72 (totally disability means "unable to perform all of the *material and substantial* duties of his occupation. . . ." (emphasis added)).

material and substantial duties of [her] occupation," authorizes Liberty to use its discretion to interpret Policy terms and make benefits determinations. *Ellis*, 394 at 266. In the exercise of the discretion, Liberty has consistently interpreted the Policy to mean that a person who can perform some material and substantial job duties is not entitled to total disability benefits. *Id*. at 271. To the extent such a person is entitled to partial disability benefits, she must be working in some capacity. *Id* at 271-72.

Based on substantial evidence in the administrative record, including information the Company received from Ellis, her doctors, her attorney, an independent medical examiner, the Company's nursing staff, and private investigators, Liberty determined that Ellis could indeed work, but was currently unemployed. As a result, the Company acted properly in terminating Ellis' benefits. Other courts, faced with the same set of facts, would likely render a similar decision. Therefore, it would be a waste of precious judicial resources for the Supreme Court to consider this case.

CONCLUSION

In the end, Ellis seeks this Court's review only to correct what she perceives to be errors in the decision below and to advocate for changes to ERISA's statutory regime. While significant to litigants, error correction "rarely" presents an issue so nationally important as to require Supreme Court intervention. This is especially true in a case like this one which presents unique factual circumstances. Likewise, the structural changes to ERISA that Ellis seeks are more properly left to Congress following investigation and debate. Finally, Ellis wants to change the way Texas regulates its insurers, she should be lobbying the State Legislative, not this Court.

Therefore, Respondent Liberty Life Assurance Company of Boston respectfully requests that the Supreme Court deny the petition for *writ of certiorari.*

Respectfully submitted,

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(3)

MAY 27 2005

No. 04-1395

IN THE

Supreme Court of the United States

LINDA ELLIS,

Petitioner,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

REPLY BRIEF

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At the heart of this case is a Circuit split involving important issues affecting ERISA jurisprudence. This Court has recognized that ERISA was enacted as a uniform regulatory regime to protect the interests of participants in employee benefit plans and their contractually defined benefits. The rules of construction pertaining to the terms of ERISA disability insurance policies and the substantial evidence requirements of the standard of review are vital components of that uniform regulatory regime that affect the millions of ERISA insureds who have purchased disability insurance coverage through their employers. The uniform application of these components is also vital to the "full and fair review" that is required to be given to disability claims under ERISA insurance policies.

In its Brief, Liberty Life has ignored these principles and attempted to misdirect the Court's attention with a combination of diversionary arguments about irrelevant factual disagreements, and strained efforts to evade or explain away serious intercircuit conflicts on these important issues. These arguments are unavailing.

Liberty Life has also incorrectly suggested that it is free to adopt any construction of "Disability" it chooses, without regard to any opinion of any federal court or any other standard. (Brief Opp. at 9). Liberty Life apparently bases this argument on its new conclusion that this case presents "nothing more than a run-of-the mill insurance dispute". (Brief Opp. at 1). Liberty Life has also incorrectly suggested the Petitioner should be "lobbying the State" legislature, if she wants to change the way Liberty Life is regulated. (Brief Opp. at 21).

Besides conflicting with the arguments Liberty Life made about ERISA and ERISA preemption below, these arguments demonstrate that Liberty Life wholly fails to appreciate the purposes of ERISA. Apparently, Liberty Life feels that ERISA should only apply when it benefits insurers, and it is otherwise free to ignore ERISA's purpose to protect participants and the contractually defined benefits they purchase in ERISA disability insurance benefit plans.

This Court's review of these important issues is imperative.

A. There is a Direct Circuit Split Regarding the Construction of an ERISA Disability Insurance Policy.

This Court has recognized that ERISA was enacted to provide a "uniform regulatory regime" to protect the interests of participants in employee benefit plans and protect contractually defined benefits. *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 124 S. Ct. 2488, 2495, 159 L. Ed. 2d 312, 326 (2004); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 148 (1985). The uniform construction of terms such as "Disability" in ERISA insurance policies is a vital component of that uniform regulatory regime. It is consistent with the "full and fair" review that is to be given to disability benefit determinations under ERISA, and the federal common law Congress "expected" courts would develop. *The Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 830-31 (2003); *Bruch*, 489 U.S. at 110; *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 56 (1987). It is also consistent with the trust-based fiduciary model this Court has recognized is applicable under ERISA. *Davila*, 542 U.S. 200, 124 S. Ct. at 2504, 159 L. Ed. 2d at 337 (Ginsburg, J., dissenting); *Bruch*, 489 U.S. at 110.

The serious and direct conflict between the majority decision of the Fifth Circuit in this case and the decisions of the Second, Seventh, Ninth, Tenth and Eleventh Circuits regarding the construction of "Disability" definitely impacts ERISA's uniform regulatory regime. The resolution of this conflict should not be avoided or explained away with suggestions that there are variances in the policy language, differences between "any occupation" and "own occupation" disability provisions, or differences in facts.

If ERISA's purpose to protect contractually defined benefits has any meaning at all, the standard for construing "Disability" under ERISA should be the same in every Circuit. Simply stated, this Court should review this case, so ERISA participants and ERISA insurers will know whether "Disability" will be

construed using the common sense, practical construction adopted by the Second, Seventh, Ninth, Tenth and Eleventh Circuits, or the overly restrictive impossible construction adopted by the Fifth Circuit majority in this case.

Under the common sense, practical construction of "Disability", an ERISA insured who is unable to perform one or more of the duties that are vital or essential to her occupation is "Disabled" and entitled to disability benefits. *Caldwell v. Life Insurance Company of North America*, 287 F.3d 1276, 1285-86 (10th Cir. 2002); *Kinstler v. First Reliance Standard Life Insurance Company*, 181 F.3d 243, 253 (2d Cir. 1999); *McClure v. Life Insurance Company of North America*, 84 F.3d 1129, 1133-34 (9th Cir. 1996); *Hammond v. Fidelity and Guaranty Life Insurance Company*, 965 F.2d 428, 431 (7th Cir. 1992); *Torix v. Ball Corporation*, 862 F.2d 1428, 1430-31 (10th Cir. 1988); *Helms v. Monsanto Company, Inc.*, 728 F.2d 1416, 1420 (11th Cir. 1984). Under the Fifth Circuit's overly restrictive impossible construction, an ERISA insured who can perform only one of the vital or essential duties of an occupation is not entitled to recover disability benefits, even if she cannot perform the occupation on an eight hour a day, five day a week basis. (App. A at 16a-17a).

This conflict is obvious, it is serious, and it can only be resolved by this Court. This conflict must be resolved by this Court, or thousands, possibly hundreds of thousands, of disabled ERISA insureds will be in severe jeopardy of having their disability claims summarily denied or terminated by insurers like Liberty Life using an overly restrictive construction of "Disability". Such a result is hardly consistent with the protection ERISA is supposed to provide to contractually defined disability benefits these ERISA insureds have purchased.

B. The Fifth Circuit Completely Disregarded the Substantial Evidence Requirement

Liberty Life's continued efforts to "spin" its unequivocal determination that Ellis was "Disabled" in May 2000 are unavailing. Contrary to its argument that it was "investigating"

Ellis' eligibility for LTD benefits and gratuitously paid her during that "investigation", Liberty Life clearly stated:

> . . . ***it is apparent you were ill and met the criteria*** for your policy's definition of disability initially based on the medical information received, ***you no longer meet*** your Long Term Disability Policy's definition of disability.

(App. B at 38a) (emphasis added). Liberty Life terminated the LTD benefits Ellis qualified for in May 2000, because Liberty Life felt she was "no longer" "Disabled" in December 2000.

Although Liberty Life now argues that there was "substantial evidence" that supported its termination decision, the Fifth Circuit failed to identify any evidence that supported any determination that Ellis was able to perform any material, vital or essential duty of her occupation. Indeed, none of the "evidence" generically referenced in Liberty Life's Brief satisfies that requirement. (Brief Opp. at 20).

All of the medical evidence from Ellis' treating physicians in the administrative record from January 2000 through March 2001 supported the District Court's finding of "Disability". These physicians determined that:

1. Ellis had a Class 4 Physical Impairment and a Class 4 Mental Impairment attributable to the persistent pain she was suffering;
2. She could not work an eight hour day;
3. She could not perform on the job driving;
4. She could not travel in a vehicle more than thirty minutes without pain medication;
5. She was unable to walk or stand for any significant length of time;
6. She could not lift, push, pull, climb stairs, or make fine movements with her hands;
7. She had memory and cognitive problems attributable to her pain;
8. She had difficulty sleeping and grooming herself;

9. She could not manage financial matters;
10. She suffered multiple areas of pain on palpation;
11. She suffered significant fatigue;
12. She met the recognized diagnostic criteria for fibromyalgia;
13. The results of her EMGs were suggestive of a myopathic process; and
14. The results of a muscle biopsy were also suggestive of an inflammatory myopathy.

None of this evidence supported a conclusion that Ellis was "no longer" "Disabled" in December 2000.

In November 2000, Liberty Life's selected expert, Dr. Croft, reported:

1. He was "uncertain" whether Ellis could stand, walk, squat, bend, kneel, climb stairs, perform on the job driving, push, pull, reach, perform repetitive movements, grasp, or perform fine finger dexterity.
2. He "cannot define this patient's limitations".
3. An FCE may be helpful.
4. Ellis became almost tearful and complained of pain upon palpation of her shoulder and thigh muscles, she had a decreased sensory response to pin prick in her hands, she had slow finger to nose testing because of pain.
5. Her gait appeared somewhat antalgic.
6. She had "possible" fibromyalgia, but he was not qualified to comment on that diagnosis.
7. He thought a repeat EMG would be helpful.
8. He thought an evaluation by a rheumatologist would also be helpful.

Dr. Croft's report and records are hardly "substantial evidence" that Ellis was "no longer" "Disabled" in December 2000. The District Court found Dr. Croft's records and opinion were not credible, substantial or positive evidence at all. (App. B. at 46a-

47a). The Fifth Circuit majority did not discuss or comment on this District Court finding in its opinion.

The information from private investigators that Liberty Life references in its Brief was videotape surveillance of fifteen minutes edited from two days of tape showing Ellis carrying grocery bags and moving a water sprinkler. The District Court found the videotape surveillance was no evidence and was inadmissible, because it did not demonstrate Ellis could perform any of the material duties of her occupation. (App. B at 44a-45a). The Fifth Circuit majority failed to comment on the District Court's ruling excluding this evidence, and certainly did not describe it as "substantial evidence" in its opinion below.

On October 17, 2000, Susan McCormack, RN, a nurse employed by Liberty Life, noted that Ellis met the criteria for the diagnosis of polymyocitis. According to Nurse McCormack, Ellis demonstrated the following diagnostic criteria of myositis/ myopathy: proximal muscle weakness, elevated CPK, myogenic changes on EMG, and non-destructive arthalgias. The notes made by Liberty Life's nurse are not "substantial evidence" that Ellis was "no longer" "Disabled" in December 2000.

The information Ellis provided included a Liberty Life Activities Questionaire, and the Social Security Administration's April 12, 2001 decision that she was "Disabled" as of October 29, 1999. This evidence also demonstrated that Ellis had numerous difficulties with daily activities, including: difficulty walking, an inability to climb stairs, an inability to wash floors, clean bathrooms, vacuum, change bed linens, or wash her car; a limited ability to drive her car for only thirty minutes usually only after taking pain medication; difficulty sleeping, sitting and standing; an inability to exercise; an inability to manage her finances; memory problems; problems even combing her hair, opening jars, and holding a pen; and significant fatigue. The Social Security Administration specifically found Ellis could not perform her occupation as a mortgage loan officer and she did not have the residual functional capacity to perform even sedentary work on a sustained basis. This is evidence that

Ellis was "Disabled" in December 2000. It is not evidence that supports Liberty Life's decision she was "no longer" "Disabled".

There is no other "evidence" in the administrative record. None of this evidence supported Liberty Life's decision to terminate Ellis' LTD benefits in December 2000. In this context, the Fifth Circuit majority's generic references to "subsequent medical evidence" and "substantial evidence" in its opinion lack substance and support. The implication of the Fifth Circuit's majority opinion is that a "self-interested" ERISA insurer, like Liberty Life, need not specifically document or identify the evidence that it contends is support for its decision to terminate disability benefits it has been paying to an ERISA insured. Of course, such a holding is inconsistent with the "full and fair review" ERISA mandates to protect the contractually defined benefits of participants in employee benefit plans.

This ruling is also clearly inconsistent with the abuse of discretion standard of review recognized by every other Circuit. *Stup v. Unum Life Insurance Company of America*, 390 F.3d 301, 307-08 (4th Cir. 2004); *Kosiba v. Merck & Company*, 384 F.3d 58, 69 (3rd Cir. 2004); *Fought v. Unum Life Insurance Company*, 379 F.3d 997, 1014-15 (10th Cir. 2004); *McDonald v. Western-Southern Life Insurance Company*, 347 F.3d 161, 169-70 (6th Cir. 2003); *Hawkins v. First Union Corporation Long-Term Disability Plan*, 326 F.3d 914, 919 (7th Cir. 2003); *Cook v. Liberty Life Assurance Company of Boston*, 320 F.3d 11, 19, 23 (1st Cir. 2003); *Caldwell v. Life Insurance Company of North America*, 287 F.3d 1276, 1282-83 (10th Cir. 2002); *Levinson v. Reliance Standard Life Insurance Company*, 245 F.3d 1321, 1325-27 (11th Cir. 2001); *House v. The Paul Revere Life Insurance Company*, 241 F.3d 1045, 1048 (8th Cir. 2001); *Pinto v. Reliance Standard Life Insurance Company*, 214 F.3d 377, 392 (3rd Cir. 2000); *Zavora v. Paul Revere Life Insurance Company*, 145 F.3d 1118, 1122-23 (9th Cir. 1998); *Woo v. Deluxe Corporation*, 144 F.3d 1157, 1162 (8th Cir. 1998); *Donaho v. FMC Corporation*, 74 F.3d 894, 899-900 (8th Cir. 1996). It is also inconsistent with this Court's recognition that an ERISA

insurer may not refuse to credit an ERISA insured's reliable medical evidence. *Nord*, 538 US at 834. This Court should also review this case to address these obvious conflicts.

C. Review by this Court is Necessary Because the Fifth Circuit's Majority Opinion is Wrong

In its Brief, Liberty Life erroneously argues that the decision of the Fifth Circuit's majority was "right" and the same result would occur in every other Circuit. Yet, it certainly appears the District Court's construction of "Disability" would have likely been affirmed in the Second, Seventh, Ninth, Tenth and Eleventh Circuits, because it was a practical common sense construction that served ERISA's purpose of protecting the rights of participants and their contractually defined benefits.

Additionally, the District Court's finding that Liberty Life abused its discretion and violated ERISA when it terminated Ellis' LTD benefits would have likely been affirmed in the First, Second, Third, Fourth, Sixth, Seventh, Eighth, Ninth, Tenth and Eleventh Circuits, because there was no concrete evidence in the administrative record that supported Liberty Life's decision. It is unlikely that any other Circuit would have reached the same conclusion as the Fifth Circuit majority on this record.

It is also significant that the Fifth Circuit majority wholly failed to even mention *Lain v. Unum Life Insurance Company of America*[1] in its opinion. It is clear the Fifth Circuit panel in *Lain* rejected the "each and every" construction the Fifth Circuit majority adopted in this case. This significant omission cannot be squared with any of the unavailing "reasons" Liberty Life has advanced in its Brief.

Liberty Life's argument that the disability provisions in *Lain* and this case are "nothing alike" strains credibility. (Brief Opp. 17). In *Lain*, the LTD policy contained the following language:

"Disability" and "disabled" mean that because of injury or sickness:

1. [the insured] cannot perform each of the material duties of [her] regular occupation; or

[1] 279 F.3d 337, 344-45 (5th Cir. 2002).

2. [the insured] while unable to perform all of the material duties of [her] occupation on a full-time basis, [is]:
   a. performing at least one of the material duties of [her] regular occupation or another occupation on a part-time or full-time basis, and
   b. earning currently at least 20% less per month than [her] indexed pre-disability earnings due to that same sickness or injury.

Lain, 279 F.3d at 343-44.

The only possible distinction between the *Lain* definition of "Disability" and the Liberty Life definition of "Disability" is use of the terms "each" and "all" in the respective policies. This "distinction" is not significant; both terms are easily interchangeable in this context. There is no way this" distinction" justifies the Fifth Circuit majority's wholesale refusal to even acknowledge *Lain*.

The Fifth Circuit panel in *Lain* would have likely found Ellis was "Disabled", because she was clearly unable to perform one or more of the material duties of her occupation. 279 F.3d at 345-46. Yet, the Fifth Circuit majority determined Ellis was not "Disabled", because she did not prove she was unable to perform "every single" material duty of her occupation. (App. A at 16a-17a).

These are two totally opposite constructions of very similar, not dissimilar, language. One of these constructions must be wrong. The *Lain* panel's opinion is clearly consistent with the opinions of five other Circuits on this issue, and the Fifth Circuit's majority opinion in this case is not.

Liberty Life further demonstrated its lack of credibility in attempting to "distinguish" *Lain* by incorrectly suggesting *Lain* "never discussed the propriety of an 'each and every' standard" for "Disability". (Brief Opp. at 16). In *Lain*, the insurer, Unum, asserted that Lain was not disabled because she did not prove "she was unable to perform *all* of her material duties as an attorney". 279 F.3d at 344-45. The Fifth Circuit determined that Unum's asserted construction was "inconsistent with a fair

reading of the policy", and "a fair reading of the policy" only required that Lain prove she was "unable to perform only a single material duty of her occupation". 279 F.3d at 345-46. *Lain* not only discussed the impropriety of an "each and every" construction like that advanced by the Fifth Circuit majority and Liberty Life in this case, it specifically rejected such a construction.

The Fifth Circuit's majority opinion also ignored the well-recognized principle that ambiguities must be construed against the ERISA insurer, and in favor of the reasonable expectations of the ERISA insured. *Lifson v. INA Life Insurance Company of New York*, 333 F.3d 349, 353 (2d Cir. 2003); *Bynum v. Cigna Healthcare of North Carolina*, 287 F.3d 305, 313 (4th Cir. 2002); *Lain*, 278 F.3d at 345; *Perez v. Aetna Life Insurance Company*, 150 F.3d 550, 556-57 (6th Cir. 1998); *McClure*, 84 F.3d at 1133-34. In the Second, Fourth, Sixth and Ninth Circuits, this rule of construction would likely result in the District Court's decision being affirmed, not reversed. The Fifth Circuit's majority was wrong when it ignored this well-recognized rule of construction.

There is no evidence in the record that supports the Fifth Circuit majority's opinion that Liberty Life's termination of Ellis' LTD benefits was supported by substantial evidence. The overwhelming evidence in the record established that Ellis was disabled from her occupation in December 2000. The correct construction of "Disability" was the construction adopted by the District Court, not the Fifth Circuit's majority. The District Court's Judgment would likely have been affirmed in every other Circuit, it would likely have been affirmed by the panel of the Fifth Circuit that authored *Lain*, and it should have been affirmed by the Fifth Circuit panel that heard this case.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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